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The Editorial Board does not necessarily agree with opinions expressed in articles and correspondence, and does not necessarily endorse courses and equipment advertised

Editorial

Happy New Year to you all.

Since the last issue the government has produced a 10 year children's plan to improve the lives of children which will hopefully deliver its aspirations that "families will be at the centre of excellent, integrated services that put their needs first, regardless of traditional institutional and professional structures..... with more effective links between schools, the NHS and other children's services". As paediatric physiotherapists we need to use the plan to our advantage in terms of the quality of services we deliver to children and families and ensure that both the clinical and service delivery aspects within our profession are of a high standard and evidence based.

We have decided that the next two journals will be themed issues. In June the journal will feature articles on Safeguarding Children and in September Respiratory Care. Articles, case studies or audits on either of these themes would be welcomed.

In the December journal I indicated that the stock of the evidence based summary of Obstetric Brachial Plexus Lesion was exhausted but it was the summary on Hip Dislocation which is not currently available.

Writing for the APCP journal gives you an opportunity to share some of the excellent practice which I know is happening and look forward to receiving a wealth of papers in 2008.

Terry Pountney

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Letters

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Dear Editor,

Response to APCP statement on training cuts in the December edition of the APCP Journal, from APCP North West Region committee

We wish to formally record our thanks to all those involved in the making and dissemination of this document and would like to fully endorse the comments contained therein concerning the scandalous situation of the current arrangements for training.

Here in the North West, we have been extremely heartened to know that the national committee have spoken up on our behalf to those in authority and in such a comprehensive way about the very difficult circumstances that so many of our members find themselves in and of the possible consequences for the future.

On a practical level, two possible strategies spring to mind that may help the situation and have actually done so in our region. Firstly, to host courses and get lecturers instead of participants to travel, thus reducing travel and subsistence costs; additionally to factor in some spare places for marketing to staff in neighbouring Trusts. Secondly, where appropriate, to explore the opportunities to market places to related professionals working in areas that may not be experiencing the same levels of financial cutbacks; this worked well for us on our recent cycling course, where PE teachers, cycling organisations and a local government disability inclusion worker joined us and made the study day feasible.

Lastly, as a region, we would like to do our part to help North West members this year by offering our courses at a heavily discounted rate. We hope that the situation may not be as grave this time next year, but who can predict.

APCP North West Regional Committee

Copy for the
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must be with the editor by

1st MAY 2008

The editorial board reserve the right to edit all material submitted

Children's and young people's ideas and opinions about the physiotherapy they receive in a special needs school: Semi-structured interviews with 11-19 year old school pupils with a neuro-disability

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Abstract

Background

The views and opinions of children and young people about the NHS provided physiotherapy service in a special needs school had not previously been sought locally. This provided the need and context for the research.

Aim

To explore the views and opinions of children and young people with neurodisability about using a school-based physiotherapy service.

Methods

Qualitative research methods were used in the form of semi-structured interviews. Students aged between 11 and 19 years, who had been receiving physiotherapy at the school for more than two terms, and had a clear method of communication, were invited to participate. Eight young people agreed to take part. Consent was obtained from parents and young people and from the head teacher at the school. The interviews were video taped to record non-verbal communication. The interviews were transcribed, coded and themed. Five core themes were identified.

Results

Young people identified a number of issues related to physiotherapy. The themes identified were choices; being informed and included; environment; child-professional relationship; views about physiotherapy. The results indicated there were markers of good practice and areas for service development.

Conclusions

The views and opinions obtained generated a richness of data and highlighted important areas of service improvement. Key areas related to understanding of physiotherapy and treatments,

involvement of young people in decision-making and offering choices. Interviewing parents and therapists would have given an added dimension to the data.

Background

The research project took place at Chailey Heritage Clinical Services which provides services to Chailey Heritage School. The children and young people (CYP) at the school have multiple and complex impairments and range in age from 3-19 years. A large number of the children and young people have conditions which affect their motor patterns, for example cerebral palsy.

With reference to physiotherapy, in general all of the students receive a weekly individual physiotherapy session with a named physiotherapist. Some young people also participate in other physiotherapy-led activities, for example, therapeutic riding. They may also have further contact with their physiotherapist and other physiotherapy staff through any clinic they may attend on the site.

Literature Review

There is a paucity of literature on consulting with disabled children. The Health Education Authority (1998) reported that little research has been done with children to address their concerns and priorities in providing quality health care services. It is now generally accepted as good clinical practice wherever possible to interview children and young people themselves as they receive services rather than relying on the perceptions and opinions of parents and therapists.

The Children's Act (DOH 1989) stated that children should participate in decision-making and their feelings and wishes should be sought. More recently the National Service Framework for Children and Young People (DOH 2004a) has outlined core standards for children's services which actively promote seeking views of individual service users. These markers of good practice outline that children and young people should be involved in their care. They should be encouraged to participate in the planning and management of services and activities they receive. The researcher believes that children and young people with disabilities have a lot to say but need to be offered the opportunity to do so:

"Disabled children want staff to listen to them, ask them for their ideas, take notice of what they say and give them choices. Children can contribute unique and essential knowledge during decision-making" (DOH 2004b pg29).

Only two studies were found which related to experiences of paediatric physiotherapy services. The first included a review of parental satisfaction with services for pre-school disabled children (Pickering 2004). Although this identifies useful

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opinions which have been considered when planning questions for this project, it does not give any insight into the views and opinions of the children. Young et al (2006) included children with cerebral palsy as well as physiotherapists and parents when exploring the experience of decision-making. They concluded that the children had some influence over a small area of decisions. The professional was seen to have most control over the treatment. Making an informed choice is an important factor in health care and a skill for young people to learn. For disabled children they often need to be enabled to make a choice. One factor is the need for medical information to be explained in appropriate language (Alderson 2000; Carroll 2002).

Garth and Aroni (2003), explored four children's experiences and perceptions of communication in a medical consultation. Although a small study, it was reported that the children had strong feelings about being included in medical consultations. A growing body of literature states that children's views are often different to those of their parents and carers and are just as valid (Garth and Aroni 2003; Watson et al 2006).

With careful planning disabled children are able to express their own views. Good practice guidelines for consulting with disabled children are very important to consider when planning the current research project. (Morris 2003 & 2002; Lewis and Porter 2004; Marchant and Page 1997).

The literature suggests that children and young people with disabilities need to be offered the opportunity to voice their views on the physiotherapy they receive.

Aim

To explore the views and opinions of children and young people with neurodisability about using a school-based physiotherapy service.

Objectives are to:

- 1 provide students with an opportunity to voice their own ideas and opinions about the physiotherapy they receive;
- 2 highlight any needs and wishes expressed by the young people;
- 3 provide feedback to the physiotherapy service about areas of good practice identified by the students;
- 4 identify any areas for service development.

Methodology

Qualitative methods were used to achieve the above aim allowing for an in depth exploration of the children and young people's views. Semi-structured interviews were chosen so that CYP had the opportunity to voice opinions which the researcher may not have considered (Silverman 2000; Holliday 2002).

Video taping was used because of the non-verbal communication methods of many of the CYP allowing the researcher to see any non-verbal responses which may have been missed during the interview.

Ethics

Ethical approval was sought and gained from the West Sussex Local Research Ethics committee.

Informed consent was sought both from the young people and from their parents. Although parents were used as 'gatekeepers' the individual had the right to consent or not consent to taking part (Lewis and Porter 2004). The children's information letter was re-read to individuals at the beginning of the interview and consent confirmed. All young people were able to withdraw from the study at any time. At the beginning of the interview it was identified how the student would tell the researcher that he/she wanted to stop the interview.

Other ethical considerations were the role of teachers, in addition to parents as 'gatekeepers'. The author gained permission from the Head Teacher of the School to conduct the study and drafted an information letter about the project which was e-mailed to school staff.

It was essential to protect the privacy and confidentiality of individuals. Students' confidentiality was maintained throughout. This was important to ensure that the young people were able to trust the researcher to maintain their confidentiality. Lack of trust in the researcher may affect how freely the young people voiced their views and opinions. All of the video tapes and consent forms were kept and stored securely in the research department's data store. For transcription purposes all participants were allocated a subject number.

Methods

All students were pupils at Chailey Heritage School in East Sussex who receive NHS physiotherapy. Purposive sampling was used because pupils needed to be able to participate in a semi-structured interview. Selection criteria were:

- aged 11-19
- had a clear method of communication (verbal or non-verbal). e.g., able to use a Chailey Communication System (CCS) with a clear Yes and No response.
- attended Chailey Heritage School for a minimum of two terms

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This age range was chosen because as young people grow into adulthood it is important to support them to make choices which affect their lives. Two terms was considered enough time to be able to comment on the service. In order to participate in interviews young people needed to have a reliable communication method. All children who fitted the inclusion criteria were invited to take part.

Twenty-three students met the inclusion criteria and were invited to participate. Information about the project for the young people and for their parents was provided in suitable formats.

Following receipt of the consent forms the author spoke privately with each young person, the study was explained and the young people chose where and when the interview would take place.

The semi-structured interviews lasted between 20 and 50 minutes and an interview schedule was used. Unfortunately there was not time to pilot the schedule or involve children in planning the schedule before the study. The interview schedule was used to guide the interview. Semi-structured interviews allowed for common topics to be discussed in all interviews to add to the data and offered flexibility to include and explore others as they arose in the interview.

At the beginning of each interview the researcher went through the children's information sheet again with the young person. The young people were then asked if they had any questions. These were answered and then the researcher asked if they were happy to continue. Consent was a continual process and the researcher had to be sensitive to the non-verbal cues of the individuals during the interview. The young people were reassured that they could stop the interview at any time or decline to answer a particular question. The researcher encouraged the young people to voice their opinions freely for example - "Can you think of a way to tell me more?" At the end of the interview young people were asked if they wanted to meet again.

Data analysis

Following the interviews, all were transcribed verbatim. Where there was non-verbal communication the researcher recorded the young person's 'yes' and 'no' responses. The researcher then met with each individual again to confirm that the researcher's interpretations of what had been said were correct.

A qualitative analysis framework was used involving organisation of data, familiarisation, and coding. Coding was done using highlighter pens to highlight recurrent themes in the transcripts (Clifford 1997; Lacey and Luff 2001; Holliday 2002). These were then used to identify emerging themes. There was not enough data to use a more in-depth analysis approach such as grounded theory.

Results

Participants

Eight young people agreed to participate in the study, 7 boys and 1 girl. They chose to be interviewed in a quiet room at Chailey Heritage Clinical Services or in the young person's bedroom on the respite bungalow. Interviews took place at lunchtime or after school. Four of the young people had a visual impairment, two communicated verbally and six non-verbally. Those who communicated non-verbally used a Chailey Communication System (CCS) book and had a clear yes and no response (Moffat 1996) Three did want to meet again after the first interview. However, only two young people were re-interviewed because the third was in hospital. All of the young people were happy to be interviewed without another adult present.

Data quality and collection

In transcribing the video tapes it was not always possible to see the non-verbal responses clearly. These were clarified for accuracy when the researcher was checking transcribing issues. The videos allowed the researcher to check that responses had been correctly interpreted at the time and in the data analysis where themes emerged. The topic guide was followed as closely as possible but not all questions were covered with all young people. The depth of discussion varied between interviews but this was expected due to the nature of the communication difficulties encountered.

One individual found direct questions very difficult to answer and this resulted in inconsistent responses. The Speech and Language Therapist recommended trying again but changing the venue to the physiotherapy gym to improve the context. This improved the quality of the data gathered from this individual and the first interview was discounted and not included in the final results.

All of the young people found it very difficult to initiate a topic. They preferred to be asked a question. Some young people found open-ended questions difficult to answer. These judgements were made by the researcher during the interview and sometimes closed questions were asked. These were sometimes asked in two different ways to be sure of consistent responses.

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Findings

The emerging themes were identified as: choices; being informed and included; environment; child-professional relationship and views about physiotherapy (including likes and dislikes).

Choices

The subject of choice emerged as some of the questions asked were to explore the young people's views and opinions in which areas of physiotherapy they had a choice. It was apparent that they were reliant on the physiotherapist to offer them a choice. Some young people felt they were not given a choice and the physiotherapist decided; others felt they were sometimes given a choice, others believed the choice to be limited. All young people agreed they wanted a choice at least some of the time.

Researcher: Do you get a choice about what you do when you go to physio? About what activity you do?

8: 'Yes' no' [nods and shakes head]

Researcher: Is that what you were trying to say sometimes?

8: 'Yes'

Researcher: Ok does it depend whether the physio offers you a choice?

8: 'Yes'

Researcher: So you have to rely on the physio saying what would you like to do today?

8: 'Yes' [nods]

Researcher: Do you think you should always be given a choice?

8: 'Yes' no' [nods and shakes head]

Researcher: Sometimes? Sometimes?

8: 'Yes'

Four out of eight young people discussed the lack of choice about the time and day of the physiotherapy session. Two young people wanted to have a choice so not to miss a particular lesson/activity. One young person reported that although he/she liked going to physiotherapy he/she would always prefer to be in class learning. Another young person recognised that he/she did not have a choice because physiotherapy had to be timetabled around lessons.

Being informed and included

Following on from having choices the theme emerged of being informed and included. These

covered sub-themes of consent, decision making, understanding reasons behind treatments and perceived needs for physiotherapy. These labels were identified through the data analysis process but were not given these labels by the young people themselves.

Identifying the young people's perceptions about why they have physiotherapy proved difficult, particularly when trying not to influence the young people's answers. They reported they had always had physiotherapy and it was part of their school routine. They found describing why they had physiotherapy difficult or did not know why they were receiving it. However some young people reported they knew why they had physiotherapy but were unable to find the words in their CCS book. Others did not know the physiotherapist's reasons for certain treatments. This quote illustrates an understanding that not all children have physiotherapy, therefore some insight into his/her disability. However, there is also an expectation that physiotherapy will stop once he/she become an adult. This possibly shows a limited understanding of the nature of his/her disability and a view that they will 'grow out of it':

Researcher: Do you know why you have physio?

1: 'No'

Researcher: No. Do you think all the other young people at Chailey have physio?

1: 'Yes'

Researcher: Do you think all other young people outside of Chailey have physio?

1: 'No' [lines deleted for brevity]

Researcher: No. Ok do you know why you have physiotherapy?

1: 'No' [lines deleted for brevity]

Researcher: Ok. Have you always had physiotherapy?

1: 'Yes' [lines deleted for brevity]

Researcher: Do you think that you'll continue to have physio when you leave Chailey?

1: 'No' [lines deleted for brevity]

Researcher: Do you want your book?

1: 'Yes' [lines deleted for brevity]

Researcher: Special days?

1: 'Yes' [lines deleted for brevity]

Researcher: Wedding?

1: 'Yes' [lines deleted for brevity]

Researcher: Somebody's wedding?

1: 'Laughs' 'yes' [lines deleted for brevity]

Researcher: Man?

1: 'Yes'

Researcher: Man. Wedding and man. [lines deleted for brevity] Any other words?

1: 'Yes' [lines deleted for brevity]

Researcher: Me?

1: 'Yes'

Researcher: So can I, may I guess what I think you've said?

1: 'Yes'

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Researcher: You think you will have physio when you leave Chailey until you become a man and get married?

1: *'Laughs'* [lines deleted for brevity]

Researcher: Have I got that correct? What I have said?

1: *'Yes'*

When answering the question about why they had physiotherapy some young people tried to use words to describe their physical disability. They commented that physiotherapy has helped them particularly when having problems e.g. concerning comfort issues related to pieces of equipment. It emerged that the young people had a clear idea with which activities they associated physiotherapy. In addition to this they knew when they needed to talk to their physiotherapist.

Researcher: Does your physio always help you with your brace?

2: *'Yes'*

Researcher: Is that one of the things physios look after?

2: *'Yes'*

Researcher: And does your physio help you sort it out when there's a problem?

2: *'Yes'*

Researcher: Do they go with you to see [name of Orthotist] to help tell him what the problem is?

2: *'Yes'*

Further questions exploring the young people's perceptions of why physiotherapists do certain activities or treatments were not well understood. The young people thought that physiotherapists had reasons why they did bike riding or stretches with the young people. However, the young people did not know what these reasons were.

Within this theme the sub-themes of consent and decision making emerged in a couple of the interviews. All young people who were asked reported that if their physiotherapist asked them if they wanted to do an activity and they said 'no', this would be listened to and respected. When describing the decision to stop using a standing frame the young person felt that he/she was involved in the decision making:

Researcher: And when you stopped standing, can you remember who made that decision?

3: *My physio and my mum obviously and me*

Researcher: And you. So you think you were involved in making that decision?

3: *Yeah*

Researcher: Who suggested it can you remember?

3: *Umm (name of physio).*

Researcher: Ok do you think if (name of physio) hadn't suggested it do you think you would have said to I don't want to stand anymore.

3: *Ahh.*

Researcher: Do you think you'd be able to say that?

3: *At some point I would of.*

Researcher: At some point you would of. Ok. And generally with the physios that you've had when you say things like that that you're listened to?

3: *Yeah*

Environment

All of the young people interviewed usually have their individual physiotherapy session in the 'physio gym'. There was a general feeling that it was a busy room with lots of physiotherapists and children coming in and out. This led to views that the room was too small. One young person felt that the gym was too close to the secondary department and if it was further away there would be fewer interruptions by other staff. These interruptions meant interruptions to his/her physiotherapy session and he/she did not like this. Paraphrased views about the physio gym include: the room was ok, that there were not enough helpers and one young person reported he/she would prefer to have physiotherapy in his/her bedroom on the residential bungalow.

The young person in interview 3 raised important issues, coded as a sub-theme of confidentiality and privacy:

Researcher: Sometimes it is not a good room for physio because...

3: *For medical reasons, like...I won't say why*

Researcher: Ok. So, for medical reasons. Why isn't it a good room?

3: *Because it has got other physios and other students*

Researcher: Ok

3: *Coming in the room*

Researcher: Ok. Is there anywhere in the room that is private?

3: *Not really*

Researcher: Even though you have got the curtains?

3: *No.*

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Researcher: Pulling those round does that make it private?

3: *No because you can still hear*

This young person went on to discuss that it can be difficult to find a private space to talk to his/her physiotherapist when it was needed.

Child-professional relationship

As described previously most young people had a good understanding of the role of his/her physiotherapist. When the young people were asked if their physiotherapist helped them at appointments several reported yes. This creates a sub-theme identified as advocacy and was important to the young people.

Researcher: Are you talking about your injections when you see Dr * (name of doctor)?

7: *'Yes'*

Researcher: For your legs?

7: *'Yes'*

Researcher: Does your physio go with you? Sometimes? And mum?

7: *'Yes' [lines deleted for brevity]*

Researcher: Is it good when your physio comes with you for your injections?

7: *'Yes'*

When considering the needs and wishes of the young people, the researcher asked if they felt able to contact their physiotherapist. Again adults were often needed to facilitate this communication. Two young people reported that they contacted their physiotherapist through their classroom staff. The young people were then dependent on the members of staff to pass on the message. One young person wanted to contact the physiotherapist himself/herself and found it frustrating if the physiotherapist did not see him/her. Some young people also discussed that they felt that their physiotherapist listened to them and what they thought were important qualities in a physiotherapist. One young person (8) felt that a physiotherapist should be fun, organised and good listeners.

Views about physiotherapy

All young people (except interviewee 5 who did not answer this question) reported what they did and did not like doing in physiotherapy. They all highlighted at least one physiotherapy activity they

enjoyed. Several also highlighted activities they did not enjoy. However they were not always able to describe reasons why they did or did not like a particular activity. Bike riding was generally quite popular, except with interviewee 4. Reasons given for enjoying bike riding included: stretch, increased comfort and a change of position. Having a change of position was chosen as a good reason for having physiotherapy but the young people who said this did not necessarily report that physiotherapy made them more comfortable. One young person reported that sometimes physiotherapy can be painful.

Researcher: After you've had physio * do you feel more comfortable? Yes? No?

4: *'No'*

Researcher: * After you've had physio do you feel pain?

4: *'Yes'*

Researcher: Do you feel pain while you're having physio?

4: *'Yes?'*

Researcher: Sorry * can I have a smile if that was a yes. Do you feel pain while you're having physio?

4: *'Yes'*

Interviewees 2, 3 and 8 also answered the following questions. The question was asked twice to ensure accuracy. Interviewee 4 answered questions 2 and 3.

Table 1: Responses to closed questions

Question	Yes	No	Don't know/ Don't mind
1. Physio makes me more comfortable?	2		1
2. I always have enough physio?	3		1
3. I always have the opportunity to talk to my physiotherapist.	2	2	
4. I understand why I have physiotherapy?	2	1	
5. My physio teaches other staff how to use my equipment.	1	2	

Discussion

As with other qualitative studies generalizability of the findings to other children's views and opinions of physiotherapy in this or another setting may be limited. The use of purposive sampling means the findings only relate to the current participants. Due to the lack of previous studies it is difficult to assess if the current findings would be typical. It may also be difficult to compare these findings with other physiotherapy services due to differences in service provision.

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Even though this study only had a small number of participants, the results are important. They highlight the experiences and views of physiotherapy in this particular service. This study provides information about areas of good practice and areas for improvement. A larger sample may have increased the number of young people agreeing with the current themes therefore increasing the strength of the data.

Reliability and validity were considered in the methodology planning. Due to the increased interpretation required with non-verbal communication the researcher checked their interpretations were accurate. This was done by repeating young people's responses back to them and then again after transcription. Checking after transcription allowed the researcher to clarify points which may have been unclear on the video, or if a non-verbal response had been missed in the interview but was seen on the tape.

While trying to encourage young people to give their views and opinions openly, the place of the researcher can not be ignored. All of the young people knew that the researcher is a physiotherapist at the school. It is possible the young people were concerned about giving the right answers. The researcher consistently reassured the young people there were no right or wrong answers. The researcher reminded the young people that the physiotherapy team wanted to know what he/she thought about how physiotherapy could be made better.

Some of the young people chose not to answer particular questions by not giving a response. The researcher felt that this could be seen as positive. The young people felt empowered enough not to answer. They chose where and when to meet. This suggests that the researcher did not have complete control over the interview and helped address a possible unequal balance of power. However, it does not rule out the possibility that the young people may have been trying to please the researcher with their answers. This problem is not unique to children and is discussed in other qualitative research (Silverman 2000; Holliday 2002).

Young people had differing views about what choices were important to them. Young people reported being dependent on the physiotherapist to offer them a choice. For example, "would you like to go for a bike ride?" is a choice of one. Children may

think this is the only activity available and say yes, although they may prefer to do something else. Physiotherapists need to be aware of this to enable choices (Carroll 2005). This is an area for service development to ensure clear communication with young people about what choices are important to them and open opportunities to make choices (Davies et al 2000). Some young people recognised the important balance between education and treatment. Young et al (2006) found children had some impact on the nature and timing of sessions and expressions of discomfort and tiredness were listened to. Some young people in the study felt they had a choice over the activity, but not over the time; this is probably due to the school environment.

From working in the service the researcher was aware that as a physiotherapist she did explain the reasons behind treatments to the young people. This raises the issue of why this was not perceived by the young people.

This theme also emerged in Garth and Aroni's study (2003) about children's perceptions and experiences of communication in the medical consultation. In the current study, young people were unclear about the reasons behind physiotherapy treatment. This is linked to consent and decision-making (Carroll 2005; Lewis and Porter 2004; Morris 2003) and raises issues about the young people's knowledge about their disabilities.

Discussing the environment where the young people have physiotherapy treatment highlighted issues about privacy for some young people. Barker and Weller (2003b) recognised in their study the difficulties in finding the right space for conducting research within a school environment to maintain confidentiality. These findings can be paralleled to this theme, for example, in the young person who reported interruptions during his/her session by other members of staff.

The role of professionals as advocates was reported in the literature (Lightfoot et al 1999). Professionals need to get to know young people and engage with them directly. This was confirmed in the current study and where physiotherapists knew individuals well they could help support them when in contact with professionals they knew less well. Muldeij (1996) commented on young people's views where professionals wanted them to do an activity and there was conflict between this and the young person's wishes. From his/her study it appears the young person was not listened to. This is contrary to the findings of the current study. Young people reported that if they did not want to do an activity they felt their wishes would be listened to.

Some of the young people reported that they enjoyed using bikes in physiotherapy and that physiotherapy offered them a change of position.

Children's and young people's ideas and opinions about the physiotherapy they receive in a special needs school: Semi-structured interviews with 11-19 year old school pupils with a neuro-disability

No comparison can be made as other literature has not reviewed disabled children's views about physiotherapy. These findings will add to the literature.

The majority of young people expressed a wish to have more choices and to know more about the reasons behind physiotherapy treatment. They need to be empowered to make choices and decisions and that these can be limited by adults. Some young people were able to identify some of the things they needed from their physiotherapist and physiotherapy. These included having an advocate; the opportunity to have a change of position; to be listened to; to have privacy; to have choices.

This study raises issues about information and how it is delivered to young people about the reasons why they have physiotherapy and the rationale behind treatments. This needs to be sensitive to individual's feelings about how much information they want to have. This needs to be considered in detail and involve the young people with careful consideration to the language used. One idea generated from the study was for the researcher to deliver a school assembly to school pupils about physiotherapy.

Another was to offer discussion with young people to recognise his/her individual needs and wishes is needed. Some young people did report that they had very good communication with their physiotherapist. However, the young people reported that areas of choice, need for privacy, decision making could be improved. These ideas will be taken back to the physiotherapy team to be discussed.

Conclusions

There needs to be recognition by health care professionals that they can open or close opportunities for children with disabilities. This is demonstrated by the young people's dependency on the physiotherapist to offer them a choice of activity in their treatment session.

Children should be involved in health care decisions if they wish to be. The data showed that this amount of involvement depended on the individual and needs to be ascertained through direct communication with the young person. Issues of consent, privacy and confidentiality need to be considered by professionals.

The study has explored the views and opinions of young people. It would be useful to gather the views and opinions of parents and physiotherapists. The researcher is aware that the study did not include children with more severe communication impairments or younger children. This would be an extension of the current study.

Appendix 1

Interview Schedule

Examples of possible questions and discussion points (these will be flexible in response to the participant)

Tell me about physiotherapy

What do you think about physiotherapy?

Do you know who your physiotherapist is?

Why do you have physiotherapy? Why do you think you have physiotherapy?

What do you like to do in physiotherapy?

What don't you like to do in physiotherapy?

Is there anything that could be better?

I don't/do like having physiotherapy - why?

What choices do you get about physiotherapy?

Time

Place

Activity

Change of Physiotherapist

Which choices are important to you?

Do you see your physiotherapist as an advocate – talk to others on your behalf.

What qualities make a good physiotherapist?

Room and space? OK?

Ideas/suggestions for changes

Why do you think you have physiotherapy?

Do you get what you want/need from your physiotherapist?

Confidentiality?

What would you tell new children about physiotherapy at Chailey?

Children's and young people's ideas and opinions about the physiotherapy they receive in a special needs school: Semi-structured interviews with 11-19 year old school pupils with a neuro-disability

Do you feel you can get hold of your physiotherapist if you need to?

Statements

Agree/disagree 1-5 scales

Physiotherapy makes me more comfortable

I always have enough physiotherapy

I always have the opportunity to talk to my physiotherapist

I understand why I have physiotherapy

My physiotherapist teaches other staff how to use my equipment

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The Use of Standing Supports for Children with Disabilities

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Abstract

Standing supports for children with disabilities are widely used although the evidence of the benefits is limited. This paper describes the results of a questionnaire that was sent out to a purposive sample of seventy physiotherapists, designed to find out about current practice of the use of standing supports. The response rate was 80%.

The most commonly prescribed standing support provided prone and upright postures. The results showed conflicting assessment criteria for the use of a prone standing position. All of the therapists agreed that the choice of standing support was based on an assessment but the criteria varied. The mean age to start using a standing support was 13.2 months (range 6-48 months). The reasons for using a standing support and what is hoped to be achieved were agreed by over 80% of the therapists i.e. increased bone mineral density, reduction of contractures, maintenance of muscle length, experience of a 'normal' standing position, for social reasons, for physiological benefits and for development of the hip joint. However muscle strength was a priority for only 64% of physiotherapists when using this equipment. 55% of physiotherapists believed that current standing supports meets the needs of the user and 30% did not.

The results indicated a need for more evidence to support the use of standing supports and guidelines for their provision and use.

Introduction

Standing supports are routinely prescribed by physiotherapists to support children with disabilities in an appropriate standing posture. Although there is much discussion about the benefits of standing supports there is limited published scientific evidence for their use particularly with children with disabilities. Their use is based on the health professionals own experience and clinical practice.

Stuberg summarised the evidence that was available and made recommendations for duration and frequency of standing programmes for bone development but these recommendations are based on anecdotal evidence (Stuberg 1992). There are not currently any published evidence based guidelines for best practice when using standing supports.

Several studies have investigated the use of standing supports to increase bone density, (Gudjonsdottir and Stemmons Mercer 2002, Caulton, Ward et al. 2004, Wilmshurst, Ward et al. 1996); measure the impact of standing position on weight bearing (Bush 2003, Stuberg 1992, Morgan, Cullen et al. 2003), the use of standing to reduce muscle spasticity (Tremblay, Malouin et al. 1990) and to maintain muscle length (Tardieu, Lespargot et al. 1988) . The studies have found benefits of using standing supports but have limitations due to small sample sizes and insufficient evidence to statistically support the claims.

Questionnaires have been used to gain feedback from adults with a spinal cord injury using standing supports (Walter, Sola et al. 1999, Eng, M et al. 2001). Individuals reported that the use of standing supports provided feelings of well being, improved circulatory, renal and bowel function and enhanced quality of life. These adult studies have been included as no research of children and young people's views of standing was found.

Alongside the benefits of standing there is very little information about the choice of standing supports available. A review commissioned by the MHRA (Daniels, Gopsill et al. 2004) describes the features of a range of standing supports for children aged between 8 and 14 years. The report describes the orientation achievable within the support but does not describe the posture achievable or the type of children who may benefit from each type of support. A guide by Ward (Ward 1983) provides some suggestions on which children may benefit from which orientation of standing support but does not provide any evidence or reasoning for the suggestions.

Little evidence about the optimum posture to achieve in standing is available. Green (Green, Mulcahy et al. 1993) discussed the developmental posture achievable in one design of standing support. Although this paper suggests theories for why the typically developing posture is recommended it does not provide evidence that this is the most effective posture that should be achieved within a standing support.

The purpose of this study was to scope current practice including which standing supports are being used, how they are being used and why. The study focused on the use of standing supports for children with physical disabilities. The

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questionnaire is part of a larger study investigating the biomechanics and kinematics of standing during development and in children with cerebral palsy.

Method

A questionnaire was developed to gather information about how standing supports are used. The survey method was used as it able to access the views of a large number of physiotherapists in a relatively short time.

The questions were developed through discussion with two locally available physiotherapists who have experience of working with children who use standing supports. Nine questions were asked covering three sections including information about; the prescription and provision of standing supports, the purpose of standing supports, and the opinion of current standing supports. The questionnaire was piloted with the assistance of locally available physiotherapists and then refined. The questionnaire was sent in 2005 to a purposive sample of 70 physiotherapists working with children with physical disabilities.

The questionnaire was sent out with a covering letter, a stamped addressed envelope and a tea bag to encourage the physiotherapists to fill out the questionnaire while having a tea break.

A copy of the questionnaire can be found in Appendix 1.

Results

Response Rate

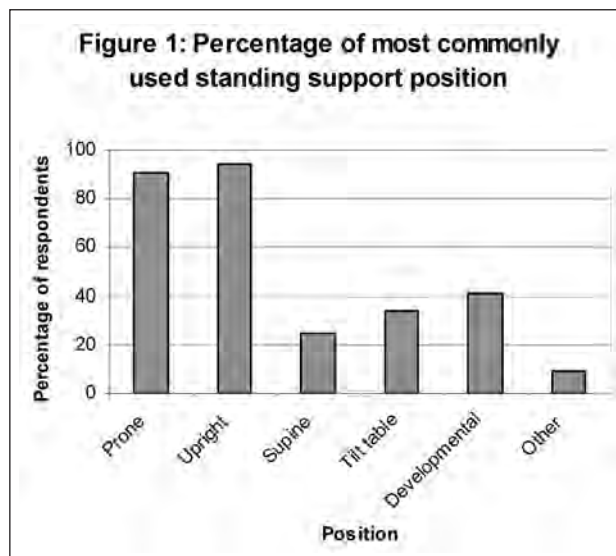
Of the 70 questionnaires sent out, 56 were returned. This represents a response rate of 80%.

Question 1: Which standing support position do you most commonly use? Why?

This question offered therapists a range of standing support positions that they may use with their client groups. They indicated all of the positions that they use. Figure 1 illustrates the use of standing supports and shows that the most commonly used standing support positions are prone and upright.

The other positioning options used were;

- "Gaiters" (2 responses) for children who are too small for standing supports, require stability around the knees or require a little support
- "Rabbit" walkers (1 response) for mobility, function and weight bearing
- "Clickers" (1 response) to give mobility in standing
- Sit to stand support (1 response) as level of extension can be controlled.



For each position selected the therapists were asked why they would use that particular standing support position. A very wide variety of responses were given to this question and some of the therapists did not give a reason why the position was used. The key themes have been described below.

The most common responses given for the use of a prone standing support was;

- Children lacking pelvic and/or knee control (18 responses)
- Children with poor head and or trunk control (16 responses)
- Children who cannot tolerate upright standing (11 responses)

Five therapists responded that they would use prone standing to facilitate a stretch on hip flexors or knees and another five use the position to promote head control. Other responses related to the favourable position achievable and the ability to promote load bearing.

The most common responses given for the use of an upright standing support were;

- More weight bearing and joint loading was achieved (13 responses)
- It was used for children who had good head control (8 responses)
- Children who were able to tolerate an upright position (5 responses)
- Children who had good trunk control (5 responses).

Some of the other responses related to the "good" position, achieved function and others gave a diagnosis or disability that this position would be used for.

The most popular reason for using a supine standing position was to ease manual handling issues (7 responses). The other responses included

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supporting a user with a complex shape, who had no head control and certain disabilities were suggested.

The tilt table was used where a prone position was not tolerated (10 responses) and again for users who had a complex shape such as fixed flexion contractures at the knees, leg length discrepancies and certain disabilities such as Muscular Dystrophy or following a head injury. It was also used if there were manual handling issues.

The reasons for using a developmental standing support position were that it was biomechanically correct (3 responses) and that it would enable weight shift. Six therapists described this position as supporting a child against furniture and two therapists did not know what this type of standing support was.

Question 2: Is your choice of standing support based on: cost, availability, assessment or other?

When asked what factors influence the choices of standing support the responses were;

- Assessment for all 56 (100%) of the therapists
- Availability for 31 (55.4%) of the therapists
- Cost for 17 (30.4%) of the therapists

In addition 11 therapists (21.6%) gave another reason for the choice of standing support. The reasons and number of therapists who gave that response have been listed in table 1:

Environment (home, nursery or school)	4
Space	4
Storage	1
What is in the department at the time of the first assessment	1
What has been supplied by previous physiotherapist	1
Ability	1
Manual handling	1
Physiotherapist's preference	1
Appearance	1

Table 1: Other reasons for choice of standing support

Question 3: What assessment criteria do you use to choose a standing support?

A wide variety of responses were given for the assessment criteria that were used when supplying a standing support. The most popular criteria were;

- Joint ranges or contractures (18 responses)
- Head control (16 responses)

- Trunk control (10 responses)
- Manual handling (8 responses)
- Ability (7 responses)
- Size or weight of child (6 responses)
- Chailey Levels of Ability (5 responses)
- Environment (4 responses)
- No formal or standard criteria (4 responses)
- Function achieved (4 responses)
- Try out standing supports and see (4 responses)
- Spinal posture (2 responses)

The other responses for this question included positioning, strength, tone, ability to weight bear/transfer, level of arousal, tolerance, respiratory function and advice from sales representatives.

Question 4: What is the earliest age you would prescribe/provide a standing support? Why?

Therapists were asked what would be the earliest age at which they would consider using a standing support. The mean age was 13.2 months (range 6 to 48 months) of the 55 responses provided for this question.

The most popular reason for supplying a support at this age (32 responses) was that it was the normal developmental age for standing. Other reasons that were given included:

- Standing at this age was beneficial for hip joint development (12 responses)
- For weight bearing (8 responses),
- That this is the minimum age that children are seen by that clinician (7 responses),
- That no smaller standing supports were available (3 responses)

There were additional responses which cited physiological and social reasons but further details were not provided.

Question 5: Is this the same as what you do in practice?

Forty one therapists (73%) stated that this was the age that they would supply a standing support in practice. Three therapists did not answer this question and one answered yes and no. The reasons for not supplying a support at the age given in the previous question are listed in Table 2:

Don't see children of that age	11
Delay in assessment and/or provision	3
Size of child/ standing support	3
Acceptability for parents	2
Not always able to get funding	1
Yes when appropriate	1
If developmental delay, will assess each child individually depends on child's needs and family/social surroundings	1

Table 2: Reasons for not supplying at standing support age prescribed

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Question 6: What do you use the standing support for? Please select as many as applicable and prioritise your answers.

When asked to prioritise what the standing support is used for 52 therapists prioritised their answers. One therapist provided two sets of results for different diagnoses and both of these have been included. 3 therapists replied with yes or no answers and these have not been included.

The total score for each factor has been divided by the number of responses received for that answer. A lower score indicates a higher priority a higher score represents a lower priority and are as follows:

Improved functional position was the highest priority	1.9
Muscle stretch	2.2
Change of position	2.9
Movement within standing position	3.0
Social reasons	3.8

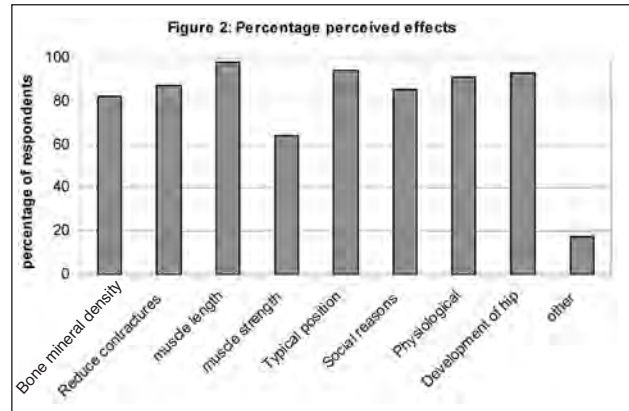
The other reasons that were given for what the standing support was used for are listed in Table 3 with the number of responses.

Weight bearing	2
Encourage bone density	8
Development of the hip socket	7
Femur development	2
Postural control and alignment	1
Maintain symmetry	1
Aid development	2
Develop antigravity muscle activity	1
Improve control of the vertical posture	1
Eye contact	1
Feeding	1
Sensory and experience of standing proprioception	1
Improve digestion to reduce constipation and muscle spasm	2
Perception, cognitive, hand function	1
Physiological reasons	2

Table 3: Other reasons for using a standing support

Question 7: What do you hope to achieve by using the standing support.

When asked to select tick boxes on what is hoped to be achieved in standing the results are shown in figure 2.



The other reasons that were given for what is hoped to be achieved in standing have been given in Table 4 below.

Improve head control	3
Function and mobility	1
More aware and alert after change of position	1
Improved arm/ hand function	2
Respiration	1
Improved communication skills	1
Improved eye contact	1
Improved interaction with peers	1
To bring hands into field of vision	1
Development of upper limb motor control	1
Developmental promotion	1

Table 4: Other reasons for what is hoped to be achieved in standing

Question 8: Do you think that standing supports meet the needs of the users?

When asking opinion of whether current standing supports meet the needs of the user 31(55%) responded yes, 17 (30%) responded no, 5 responded yes and no and 3 did not answer the question

Question 9: Please explain your answer

When asked to explain their answer there was a large number of different comments. Some of the themes have been listed below.

- Posture and function achievable within the support
- Comfort in the support
- Aspects of the design of the standing support make it difficult to use and aesthetics.
- Parental acceptability
- Problems with space and manual handling

Discussion

Sample

The sample of physiotherapists was chosen from a group who had expressed an interest in helping with research. The therapists were selected by their specified interest or their work location. Targeting

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this population may have biased the results but should have provided answers from a knowledgeable group whose approach reflects current best practice.

Position within a standing support

There are many different styles of standing support available on the market. From the results it can be seen that the upright and prone standing support positions are the most commonly used and this is reflected in the selection of standing supports that were investigated in the MHRA evaluation report (Daniels, Gopsill et al. 2004).

The results of the questionnaire indicate that the prone standing support position is most often used for children who are lacking pelvic and or knee control. This does not contradict Ward's recommendations (Ward 1983) providing a symmetrical posture with no contractures and stable hips is achievable. The therapists use the prone standing support for children who have a low level of trunk and head control whereas the advice by Ward which is not so recent suggests that prone standing supports should be used by children who have good head control and at least moderate trunk control.

The upright standing support is used by the therapists to promote weight bearing and joint loading if children have good head control. Ward's advice agrees with this (Ward 1983).

The position described as a developmental standing position in the questionnaire was viewed in different ways depending on the therapists own experience. This was apparent from the responses received. Some responses indicated that this was a "free" standing position. The intention had been to ask about the use of standing supports that provide a developmentally appropriate posture, for example the Chailey Standing Support (Green, Mulcahy et al. 1993; Pountney, Mulcahy et al. 2004). Two responses indicated that they were not aware that they were available. This type of support has only recently become commercially available and therefore many therapists may not know of its existence.

Choosing a standing support

All of the therapists base their choice of standing support on an assessment but the assessment criteria varied. The majority assessed the children by body segment control and joint range of movement. Although this gives a clear description of the child it is not evident how this information is used to evaluate the effectiveness of a standing support. X rays (Miller and Bagg 1992) could be used to assess

the child for the presence of bony changes but were not mentioned in any of the responses perhaps this is due to limited access.

Some therapists used a trial and error method to assess the effectiveness of a standing support. This type of assessment only allows a comparison between supports and may not provide a full understanding of the issues as areas may be masked if assessments are only being carried out within a range of standing supports.

Although some therapists used a validated measure the results indicate that no recognised assessment method is being widely used to assess standing. A validated measure such as the Chailey Levels of Ability (Pountney, Mulcahy et al. 2004) could be used to assess the ability of the child in standing and then used as an outcome measure to assess the changes that result from the provision of a the standing support. Although not specifically asked for no outcome measures appear to be routinely used. There are many other outcome measures available including the GMFM (Gross Motor Function Measure) (Russell, Rosenbaum et al. 2002). A better response to this question would have been achieved by listing a selection of assessment tools and outcome measures rather than asking for assessment criteria.

Age to begin standing

The mean age given to begin to use a standing support was 13.2 months (range 6 to 48 months). The most common reason given for beginning to stand at this age was that it was the normal developmental age for standing. Some of the therapists did not see younger children and this may explain why they had suggested a higher age for starting to use standing supports. The questionnaire did not ask if the children were being seen by another physiotherapist who may have provided a standing support before.

Other comments discussed the problems of the availability of small enough standing supports for very young children. There are some standing supports available in small sizes (for children from 9-12 months) but they may only be recently commercially available. These include the Chailey standing support, the Jenx Monkey and Cat standing supports.

In practice most therapists prescribe standing supports at the age stated but consideration was also given to the acceptability of the support for the child and family. If standing supports do provide important benefits if prescribed at the correct chronological age then it would be interesting to find out the reasons that families do not want to use them at this age and if anything could be done to address them.

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Why are standing supports being used

Over 45 (80%) of the therapists (range of responses across the criteria 46 to 55) hoped to achieve increased bone mineral density, to reduce contractures, to maintain muscle length, to experience a 'normal' standing position, for social reasons, for physiological benefits and for development of the hip joint. However when the literature (Gudjonsdottir and Stemmons Mercer 2002, Caulton, Ward et al. 2004, Wilmshurst, Ward et al. 1996, Tardieu, Lespargot et al. 1988; Tremblay, Malouin et al. 1990, Walter, Sola et al. 1999, Eng, M et al. 2001, Stuberg 1992) is considered there is very little evidence to support the use of standing supports for children with cerebral palsy for these reasons.

When asked to prioritise what a standing support was to be used for improved functional position was the highest priority however function was only mentioned as an assessment criteria by 4 therapists. This may indicate that although it is considered as important it is not measured during the assessment process. Muscle stretch was the next highest priority and this may be accounted for in the assessment criteria by assessing ability, joint ranges and contractures but no mention of measurement of this was made.

Improving muscle strength in a standing support received 36 (64%) responses. In the previous question improved function was chosen as a high priority. In order to function muscle strength is required so both aspects could be considered as equally important.

What is the therapist's opinion of standing supports?

Only half of therapists felt that standing supports currently meet the needs of the user. It may be beneficial to have objective measures to support this. It indicates that although standing supports provide the posture and function required for some children there is room for improvement in the current designs. This would require assistance from the therapists, children and families routinely using standing supports.

In General

The questionnaire attracted a wide variety of different responses in the free text boxes. This was surprising as it was thought that physiotherapists would use standing supports in a similar way for a given range of disabilities or abilities. The varied results however do support the need for evidence and guidance for the assessment for and use of standing supports which is not currently evident from the literature.

Some of the comments were ambiguous and therefore hard to interpret. An example of this is the use of a standing support for development of the femur. From this comment it is not clear if the therapist is using the standing support to increase bone mineral density in the femur or for the development of the proximal femoral anatomy (shaft angle).

The results do not show a clear consistency in the provision of standing supports for children with a physical disability. In answer to several questions a maximum of 32% (18) of the therapists answered in a similar way. Examples of this are; why a prone standing support position was selected and the main assessment criteria. There may be consistency which is masked by the questionnaire format, not specifying a particular disability or in the interpretation of the answers.

Limitations

The questionnaire had some limitations including how therapists interpreted some of the questions in different ways e.g. the developmental standing position which was an unfamiliar type of support for some therapists.

Some of the therapists gave an age range when asked for the youngest age and therefore in the analysis the lower limit was used.

Some confusion arose in recording priorities. Where a range was given the highest priority was selected, and when other ticked the boxes rather than giving a figure these results were not included.

Conclusion

From the results of the questionnaire and the review of the literature it suggests that physiotherapists are using standing supports for the range of reasons that are widely reported but not evidenced based. Research is therefore required to ensure that standing supports are achieving what is reported. The research should include both quantitative and qualitative methods and the studies developed with the children's views and priorities as a central requirement. The evidence resulting from these studies would then provide the information required to ensure that the reasons for standing were clear and evidenced based. The results would also provide information required in the development of guidelines and would inform the design of future standing supports.

The results do not show a clear consistency in the assessment and outcome measures used in the provision of standing supports for children with a physical disability. It would be beneficial therefore to investigate the identification or development of an appropriate assessment method and outcome measures to evaluate their use. This would also inform the development of guidelines.

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The results show that the current design of standing supports does not meet the needs of the users and this needs addressing from a research and design perspective. Manual handling was highlighted as one current particular area of difficulty.

A focus group may help to highlight more specific issues but the questionnaire provided a good overview of usage of standing supports. Some of the questions could have been clearer to enable easier analysis however a wealth of data was collected which may benefit from further analysis of the free text with a qualitative research package. A further questionnaire may help to further clarify some aspects of the comments received in the free text boxes.

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APPENDIX

Standing Support Questionnaire

About the prescription and provision of Standing Supports

1. Which standing support position do you most commonly use? Please tick as many as applicable and for each you chose state why you would use this position.

Prone standing
Why?

Upright standing
Why?

Supine standing
Why?

Tilt table
Why?

Developmental standing position
Why?

Other, please specify
Why?

2. Is your choice of standing support based on:

Cost Yes No

Availability Yes No

Assessment Yes No

Other Yes please specify _____ No

3. What assessment criteria do you use to choose a standing support?

4. What is the earliest age you would prescribe/ provide a standing support? ____

Why?

5. Is this the same as what you do in practice?

Yes

No

If not, Why

Please turn over

The Use of Standing Supports for Children with Disabilities

About the purpose of standing supports

6. What do you use the standing support for? Please select as many as applicable
Please prioritise your answers (1=high priority, 5= low priority)
- Change of position
- Improved functional position
- Muscle stretch
- Movement within standing position
- Social reasons
- Other Please specify _____
7. What do you hope to achieve by using the standing support? Please select as many as applicable
- Increased bone mineral density
- Reducing contractures
- Maintaining muscle length
- Muscle strengthening
- Experience of normal standing position
- Social benefits (e.g. inclusion)
- Physiological benefits
(such as improved bladder function or circulation)
- Improved development of the hip joint
- Other Please specify _____

Your opinion of current standing supports

8. Do you think that current standing supports meet the needs of the users?
Yes
No
9. Please explain your answer

Thank you for taking the time to complete this questionnaire.
Please return it to me in the enclosed stamped addressed envelope.

Developmental co-ordination disorder - APCP survey

Sally Braithwaite MCSP, SRP, Senior Paediatric Physiotherapist, Team Leader, Birmingham
Judith M. Peters PhD., MCSP, SRP, Honorary Clinical Specialist Physiotherapist, Great Ormond Street Hospital, London
Address for Correspondence :- Sally Braithwaite, Physiotherapy Dept, Victoria School, Bell Hill, Northfield, Birmingham B31 1LD

Introduction

Clinical practice adopted around the United Kingdom (UK) when working with children with a diagnosis of Developmental Coordination Disorder (DCD) has for many years varied significantly, even down to whether active intervention was offered or not and which Allied Health Professional/s the child might see.

The Association of Paediatric Chartered Physiotherapists (APCP) has been working for several years toward developing evidence-based clinical guidance. These have already been published by APCP for Hip Dislocation in Children with Cerebral Palsy; Obstetric Brachial Plexus Palsy; and Use of Botulinum Toxin in Children with Neurological Conditions. Production of guidance for service provision for children with Developmental Coordination Disorder (DCD) is currently in progress. Following joint meetings with Occupational Therapy (OT) colleagues and publication by the College of Occupational Therapists of a comprehensive review of DCD waiting lists (Dunford & Richards, 2003) we decided that it was important to gather similar information regarding physiotherapy practice. APCP, through the DCD scoping group, aimed to try and establish an overview of DCD service provision through a questionnaire survey distributed to a representative sample of physiotherapists across UK.

In autumn 2005 a questionnaire was designed by the scoping group and piloted to 12 paediatric physiotherapists known to be working in the field of DCD. In the light of their responses this questionnaire was reviewed and slightly amended to ensure that the questions were clear and concise and would provide the information we were seeking.

The questionnaires were distributed in December 2005 via APCP regional representatives to a sample of 48 paediatric physiotherapists across UK. The survey gained information from England (North

East; North West; London, East Anglia, the Midlands and South East; South West); Scotland; Wales and Northern Ireland. This information will be used to help standardise service delivery and offer guidance that clinicians might use to inform their local practice. At this stage we would like to share briefly with you the results of the survey, prior to sharing guidance for service delivery and good practice.

Information Collected

- Grades of therapist respondents
- Types of workplace
- Referral practices
- Priority for treatment
- Waiting times
- Uni-agency therapy input / multi-agency therapy input
- Assessment tools used
- Therapy interventions available
- Outcome measures used

Results

48 questionnaires were sent out to representative physiotherapists throughout the UK. 41 replies were received which was a gratifying 85 % of the total. Although as it turned out several of these were from physiotherapists working in the acute sector who did not provide any service for children with DCD.

Participants

Questionnaires were returned by physiotherapists who gave their grades in terms that we all know of old (pre-Agenda for Change) as not everyone had settled their Agenda for Change banding. There was an obvious wealth of experience amongst the respondents with replies from clinical specialists, senior and superintendent physiotherapists, team leaders, principals, manager and heads of therapy. One gave their job title specifically as a clinical specialist in DCD rather than paediatrics in general. There were 36 replies from NHS employed physiotherapists, 4 from those in the private sector and 1 from a physiotherapist employed by a charity.

Service Provision

We wanted to know what kind of service, in terms of assessment, was offered in different service structures. This information is shown in Fig 1. Although the numbers of physiotherapists surveyed was relatively small, within the 41 replies a high percentage of respondents providing both assessment and input seemed to be firmly based in various community and paediatric out-patient settings throughout the UK. Whilst those who replied that they worked in an acute hospital environment did not seem to have children with DCD referred to them and therefore returned their questionnaire with the comment that there was no service provision for DCD. Another instance of failure to provide a service for children with DCD

Developmental co-ordination disorder - APCP survey

was related to lack of resources: "Service currently suspended due to lack of resources but there are plans to re-start either with NHS or Charity funds".

The majority (>90%) of respondents in our survey worked within the National Health Service (NHS). Private therapy intervention was available with one would suspect its use being largely driven by the prospect of NHS waiting lists.

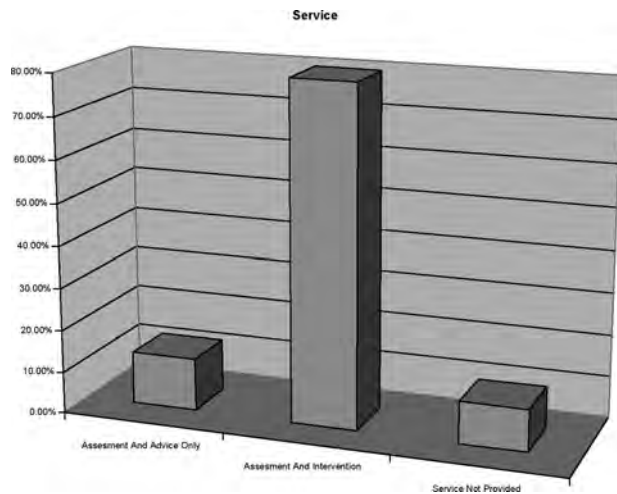


Fig 1 Proportion (%) of respondents providing assessment + advice; assessment + intervention; or no service provision

Referral Pattern

Patterns of referral were observed. Each respondent could tick as many referral sources as were applicable (Fig 2). In our survey it was very apparent that therapists received the bulk of their DCD referrals from their local paediatricians and other Allied Health Professionals. However, referrals were also received from GPs, psychologists and educational professionals.

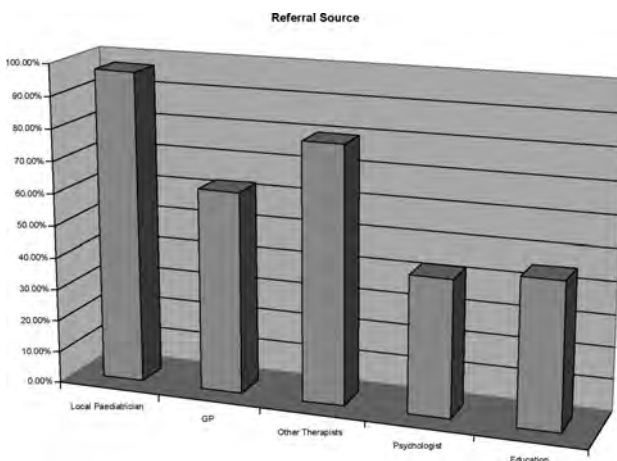


Fig 2 Sources of referrals expressed as percentage of questionnaire responses returned

As part of the referral process we asked to which therapy service (OT or PT) young people were initially referred and whether there were specific referrals to both physiotherapy (PT) and occupational therapy (OT). The data in Fig 3 show that referrals were most often received individually by both therapy modalities. However, around 50% of respondents said that referrals to their service were to a joint PT and OT team rather than separate referrals. Sometimes the referral process varied according to the child's main presenting symptom and some respondents commented that only PT received referrals as there was no OT service.

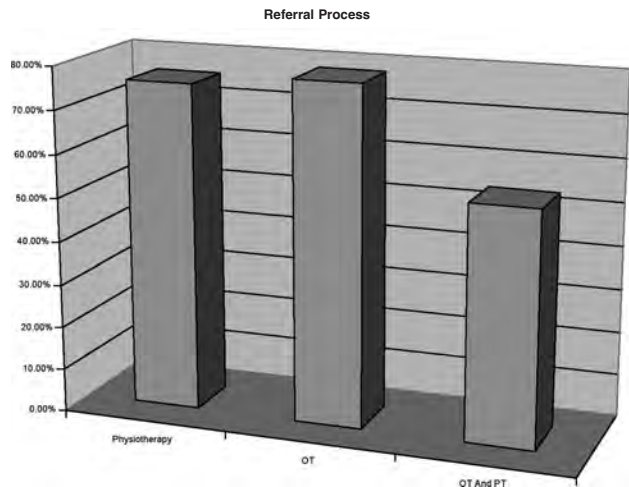


Fig 3 Direct referral to PT, OT or joint referral to PT and OT (expressed as percentage of questionnaire responses returned)

Waiting Times

Fig 4 illustrates the assessment waiting times submitted for the referrals received. One or two people commented that waiting times for children with DCD could fluctuate depending on the overall waiting list for all referrals received. Whilst only two people said that their waiting times were from a purely DCD generated waiting list, these latter returned the very low assessment waiting times by default. Whilst it has been reported that DCD occupational therapy waiting times ranged up to 4 years (Dunford & Richards, 2003), in the present small survey 80% of physiotherapy respondents said that children waited 6 months or less for a physiotherapy appointment and no child waited over 2 years. The number of children on waiting lists was in the main under 15 but ranged from under 5 to, in one instance, over 100.

We received the following comment from one respondent: "We triage all new referrals so they are seen within one month, but may go on to a w/list after" (Note: this questionnaire had 0-5 children on the waiting list).

Developmental co-ordination disorder - APCP survey

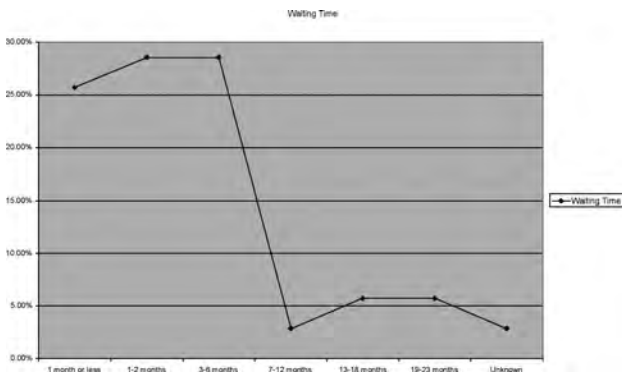


Fig 4 Waiting time for physiotherapy appointment expressed as percentage of responses. (Note: 'unknown' refers to incomplete questionnaires).

Assessment

Specific information was gathered on the kind of assessment on offer. Was this a multi-disciplinary package? Could a child be seen by both physiotherapy and OT but only separately? Was a uni-disciplinary assessment only offered. Fig 5 shows that in the majority of instances uni-disciplinary assessment was offered however around a quarter of respondents said that assessment was multidisciplinary and 10% of responses revealed that both uni- and multi-disciplinary options were provided. The small number who failed to complete this question, represent those acute services that do not offer input for DCD.

Additional comments provided by respondents included the following:

"OT and PT do separate assessments. OT include M-ABC + VMI. PT follows own DCD assessment + school and parent questionnaires. The information gained is then discussed at joint OT/PT meeting".

"We do joint OT/PT assessment, OTs then do:- VMI, handwriting assessment etc."

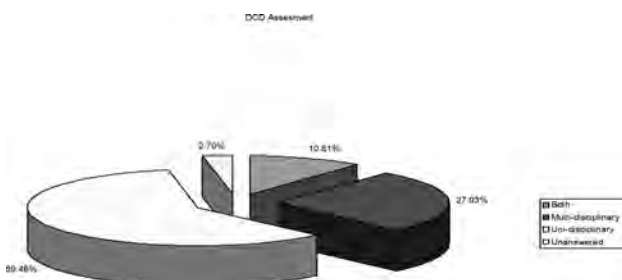


Fig 5 Proportions of responses providing uni- or multi-disciplinary assessment

Priority

Fig 6 shows the priority given on waiting lists for children with DCD, in terms of their age. In the present sample, assessment and therapy support were offered across the whole paediatric age range with significant priority being given to younger children (pre-school and primary school). It was not possible to tell from this questionnaire whether this age group was in fact the one with the greatest referral numbers. A few respondents commented that they gave priority to a child at the stage of school transfer. Many remarked that prioritisation was not set in pillars of stone and varied according to perceived need.

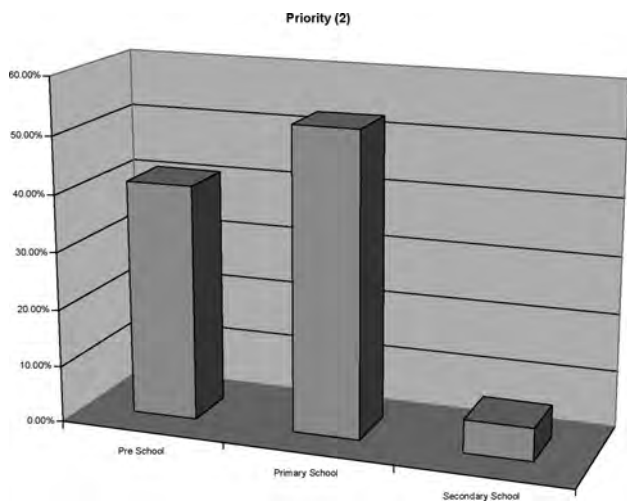


Fig 6 Responses (%) giving greater priority for physiotherapy by age

The survey also looked at the priority for physiotherapy, given to children with DCD compared to those with mild and severe cerebral palsy. Fig 7 shows that children with DCD were usually given lower priority than referrals for severe CP but when DCD and mild CP were compared the child with DCD was often given equal priority for direct treatment intervention. Again, physiotherapists said that there was variability depending on the child's needs, demands on the service as a whole and availability of staff.

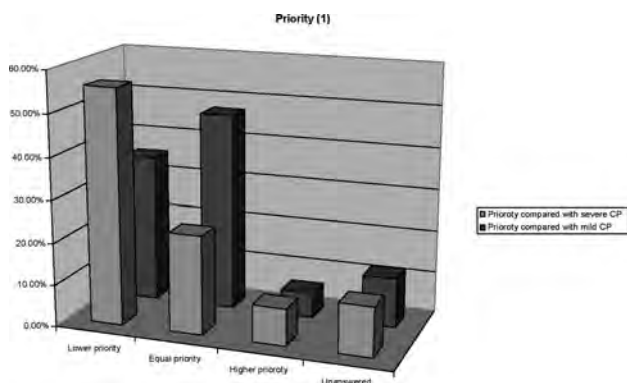


Fig 7 Responses (%) giving lower, equal or higher priority to referrals with DCD compared to those with severe or mild Cerebral Palsy.

Developmental co-ordination disorder - APCP survey

Assessment Tools

We also gathered the range of assessment tools used by the participants in our survey (Fig 8). All our respondents used some type of clinical observation as their baseline for assessment. Some used norm referenced standardised assessment tools, whilst other physiotherapists had clearly developed locally driven non-standardised assessment protocols. Over 50% of participants used the Movement Assessment Battery for Children (M-ABC) and 20% used the associated M-ABC teacher checklist (Henderson & Sugden, 1992). Three participants used the Bruininks (Bruininks, 1978). Several physiotherapists included The Developmental Test of Visual Motor Integration (VMI) (Beery, 1997); handwriting evaluation (generic); behaviour questionnaire; hypermobility assessment (Beighton) (Grahame, 2003), muscle testing and joint range. Sensory Integration and Praxis Tests (SIPT) (Ayres, 1989); Miller Assessment for Preschoolers (MAP) (Miller, 1988); Sensory Profile (Dunn, 1999), Perceived Efficacy and Goal Setting System (PEGS) (Missiuna et al 2004) were mentioned occasionally. Other assessment protocols used included Mini Assessment (RHSC Edinburgh), and assessment procedures devised by Michelle Lee and by Sally Wright (physiotherapists with their own private practices). None of our participants responded that they used the Developmental Coordination Disorder Questionnaire (DCDQ) (Wilson et al 2000), the Test of Gross Motor Function (TGMF) (Ulrich, 2000) or the Clinical Observation of Motor and Postural Skills (COMPS) (Wilson et al 1994).

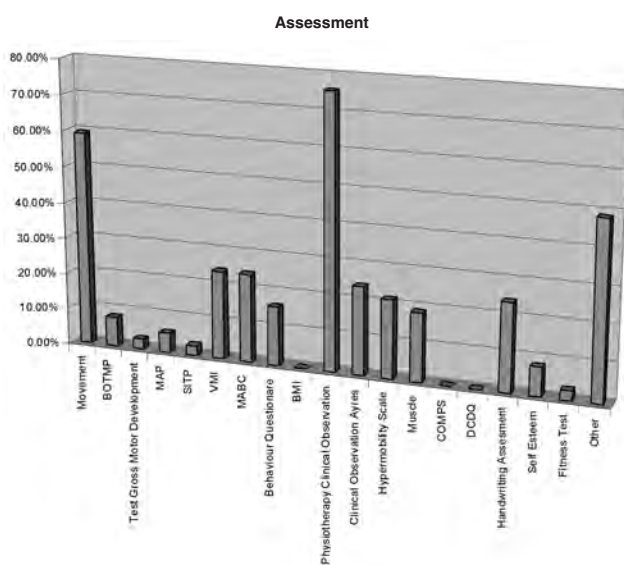


Fig 8 Respondents (%) using a variety of assessment tools.

Intervention Modalities

Even in this small group a wide range of therapy intervention modalities were employed, based upon assessment results and local resources (Fig 9 and Fig 10). More than one intervention modality was employed by many of the participants and these may have been used individually or more often combined together and considered as 'eclectic'. Most frequently treatment was delivered 1:1 through NHS physiotherapy services. Classical exercise formed the frequent base but some used specific approaches e.g. Sensory Integration Therapy (Ayres, 1989) Cognitive Orientation to Daily Occupational Performance (COOP) (Missiuna, et al., 2001); and local programmes: BEAM (Balance, Education And Movement) (Maidstone Weald Primary Care Trust), Fizzy Training Games (East Kent Community) Fig 9 also shows NHS and private therapy interventions, along with combined therapy inputs offered with OT and speech and language therapists (SALT) when these are available. It was encouraging to see signs of joined up working across health and education, the use of groups and the extension of physiotherapists actively involved in, or making recommendations for, activities such as swimming, rebound therapy, fitness training and other out of school programmes.

The following comment from four different respondents illustrate that physiotherapists try to tailor their involvement to meet local need.

"Children may be seen on a review + home prog basis (most frequent approach). We are developing a DCD review clinic. Groups take place as appropriate to client group – children with greatest difficulty during term time, transitions group for those starting school, booster group (secondary transfer) and other groups in summer holidays"

"Specific gross motor programmes have been developed and delivered in conjunction with education outreach service"

"Established gym clubs with OT/PT lead. In school – individual programmes with support from teaching and or PE staff"

"Schools outreach multisensory fine motor and handwriting programme running in a school for 6 weeks with school staff"

Developmental co-ordination disorder - APCP survey

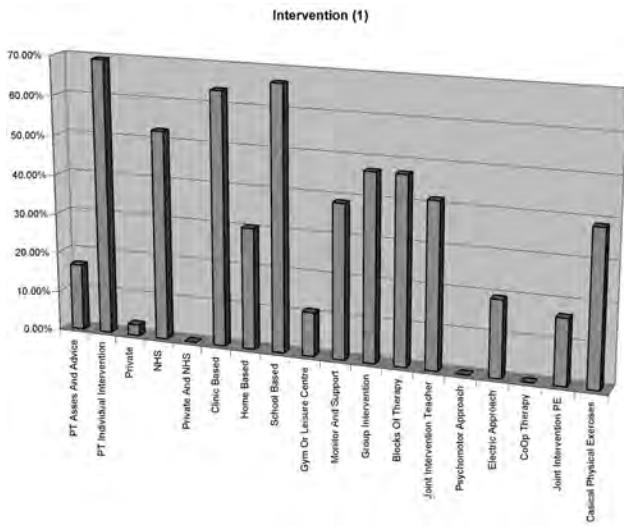


Fig 9 Responses (%) to show breakdown of interventions: private, NHS, individual, group.

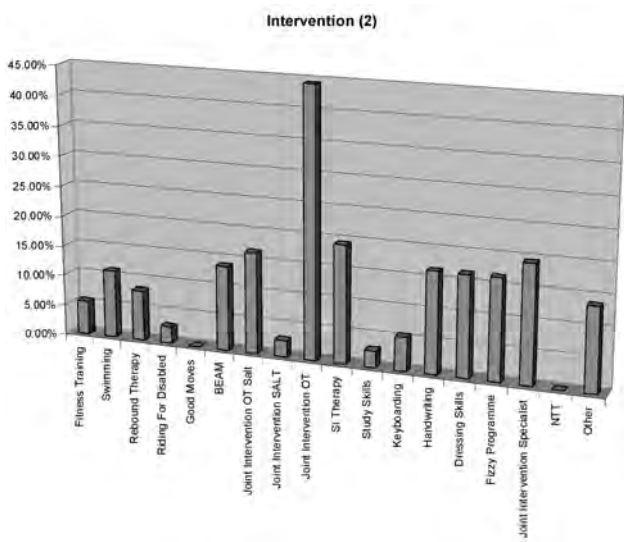


Fig 10 Responses (%) to show breakdown of interventions provided

Outcome Measurements

Evaluating therapeutic intervention is an essential foundation stone toward the development of evidence based practice in line with core standards of physiotherapy (CSP, 2005). Fig 11 shows the outcome measurements used by the participants in this small survey. The majority of participants relied on subjective clinical observation and feedback from parents and teachers to measure progress. 60% of respondents said that they used standardised tests in their assessment and also used these as an outcome measurement. Where locally devised assessment tools were employed these also seemed to have an inbuilt outcome measurement component although their reliability is open to

question. A few respondents capture children's movement function using video recording.

Two examples of comments relevant to evaluation and outcome measurement are provided below: *"Just started to use child self rates + therapist rates, specific functional goals, pre- post treatment"*

One participant indicated that their department used TELER (Le Roux, 1993) to monitor the DCD service.

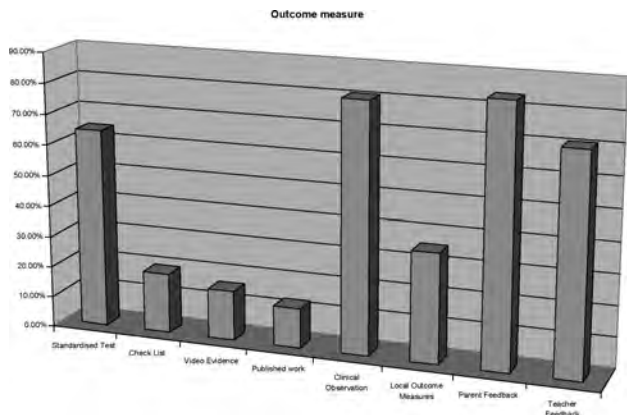


Fig 11 Responses (%) to show use of outcome measures

Within this small survey, sadly only three people working clinically in the DCD field have published their work in general, or the outcomes they have achieved. Undoubtedly some very good work is under way but it is essential for everyone to publish and share what they are doing in order to achieve a consensus on the way to move forward and to ensure equity for children and families across all services.

Summary

The results of our questionnaire survey show that in this small sample of physiotherapy services there is currently no standard protocol for the referral, assessment, or intervention for children with DCD in the UK. Although from such a small sample, results are not necessarily generalisable throughout UK, our findings reflect recent reports from others e.g. Dunford & Richards, (2003); Sugden, (2006); NHS QIS (2007). There is a need to gather and share evidence, and examine models of practice employed by AHPs for DCD, across the UK. This will support our aim to develop guidance and to expand further APCP Paediatric Outcome Measurement. We are in the process of completing guidance on DCD that physiotherapists will be able to use within the boundaries of protocols and care pathways set up by individual trusts. This should be available through APCP in the near future.

We would like to thank everybody who contributed to our information collection and for all the helpful

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comments and ideas that were sent with it.

Particular thanks are due to David Hextell for statistical analysis of the questionnaires.

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National committee meeting

The first National committee meeting of 2008 was held at CSP on Friday 1st February; with meetings of the editorial group and research and education group being held on Thursday afternoon. High winds and severe weather warnings upset the travel arrangements for several committee members however the committee was only slightly depleted with 19 members in attendance. As we were meeting at CSP Bedford Row we were also able to arrange informal sessions with CSP advisors giving us the opportunity to highlight the paediatric physiotherapists' perspective and agenda

The day began with a meeting of Regional and Affiliated group representatives. Although there was a wealth of activity to report and discuss, there was a common theme of committee members having difficulty obtaining leave to attend meetings and committees having difficulty replacing committee posts.

Peta Smith later reported that she had received some positive responses to the statement relating to training cuts circulated in November last year.

APCP will be first time exhibitors at the Primary Care conference from 21-22 May 08. We hope to promote general awareness of the range and diversity of paediatric physiotherapy practice. Di Coggings will also contribute to the programme of paediatric speakers

APCP has been invited to send a representative to a steering group meeting to review the final draft of updated RCN paediatric pain guidelines. Jeanne Hartley will attend on our behalf

An earlier meeting of the competencies working group had been attended by Julie Sullivan of CSP. It was proposed that APCP work with CSP to be pro-active in compiling a promotional document including service exemplars for commissioners and the general public. You will see requests for good practice examples on iCSP and from your regional representative

Plans for the new website are progressing well and it is hoped to have it live by March 08.

Barbara Connolly chair of the newly formed International Organisation of Paediatric Physical Therapist (IOPTT) a sub group of the WCPT has invited APCP join and contribute to sub committee activities. Laura Wiggins has agreed to be part of the communications group and other volunteers are sought

The PRO group met to review our current publications and to discuss the format for distributing future publications. Although we would hope to have our publications as downloadable documents for our members on the website, it was agreed that paper copies would still be available. The Evidence Based Guidance for Physiotherapists, The use of Botulinum Toxin in Children with Neurological conditions has been completed and will be with the printer in March

Sharon Dyer is taking over some of the administrative and organisational tasks previously carried out by the Secretary and membership secretary and to support the journal Editor. Christine Sneade has taken over the role of PRO and the role of the Publications officer will change to include reviewing the content and highlighting the need to update publications.

The next committee will be held on 11th April, contact your representative if you wish to raise any issues or would like more information

Laura Wiggins

Research and Education

RESEARCH

Remembering that this piece will have been written in January, how many of you still have New Year Resolutions intact? One of my many resolutions, to go to the gym at least twice a week, was compromised by illness at the start but now I am back on track and feeling much better for it. The BIG RESOLUTION, though, is to write up my MSc project for publication – something I have promised to do for at least two years – and get nagged about unbelievably regularly! I also want to make some attempt at getting the 'Arthrogyrosis in Adulthood' study published too so it looks as if things will be pretty busy for me over the next few months. I seem to remember that the MSc thing also featured in last year's resolutions as well as the year before that so I do need to get it sorted.

But what are you lot doing about publishing your research? Perhaps your resolution should be to get onto it yourself. Deciding on the right journal to disseminate your findings can be challenging but if you have a look at appropriate journals for your subject then there is almost always a section on advice for authors. Looking through the journal should give you some sort of indication as to where your contribution would sit well. Deciding whether it should be in a 'therapy' publication or somewhere else can be a little more tricky – consideration should always be given to the target audience and the message you want to get across!

When listening to the radio over the Christmas break I heard a doctor say '*if you don't have a scientific basis for your medicine you are essentially a quack*'. If I was to exchange physio technique for medicine how comfortable are you feeling about your working practice? One of the family mantras I was brought up on was 'question and challenge'. If we, as a profession, don't question and challenge our practice then I think there will be little evidence to back up paediatric physiotherapy when the day comes. We will be asked to prove to our commissioners that what we do really makes a difference to the children and young people on our case load. So much of what we do seems to have little scientific back up and we seem to be content to carry on because this is the way it has always been done or this is what I learnt on a course. Prove why things work, equally don't be afraid to show that certain treatments make no difference - question and challenge!

So my challenge to you in 2008 is to get down to it. You don't have to do it on your own. I know of a couple of studies being undertaken by teams working together. If you look on iCSP topics keep

recurring (positional talipes, standing frames to name just two off the top of my head). Perhaps some of you posting queries on the website could get together. In your local APCP area are there any of you with similar interests/passions that could bring together experience and importantly patients to increase the numbers in a study?

I do hope you enjoyed reading about the research supported by APCP in the last Journal. As yet we are not able to announce when there will be money to support further bursaries but there are other sources of funding that appear on iCSP from time to time. Please look – if you get on-line now you will see that there is lots of funding available if you look on the CPD site. There is info on money from the CSP Charitable Trust which supports CPD and development of the physiotherapy profession which is offering support, for the first time, to new graduates. CSP is also inviting applications for funding towards MScs (including modules), MAs, PhDs, post-grad diplomas etc.

Also there are also other funding options: the International Development Award, The UK Presentation Fund and International Lecture Fund and not forgetting the Baroness Robson Fund to help those of you who ask me where they can get support for presenting their work in the UK or at conferences abroad when help is not forthcoming from their Trusts. I would suspect that these CSP monies will become more important to us all in the future.

For most of these awards it says the next application deadline is 1st March 2008 – too late for you I know but there will always be another deadline and you will have plenty of time to make yours so stunning that the CSP will be bowled over and give you oodles of dosh.

The CSP also have useful information papers:

- Sources of Research Funding (RES3)
- Sources of funding for post-qualifying education (CPD12)

For those of you awaiting news of potential funds from APCP I have to tell you that at the present time there are no spare funds available to support a further bursary round. As soon as the position changes I will of course let you all know!

Go forth – question and challenge!

Jeanne Hartley
Research Officer

EDUCATION

I hope that you enjoyed the varied programme that the conference offered in November. I was sorry to miss this and especially not to hear the free papers and posters that we had selected to represent the excellent research work going on around the United Kingdom.

To update you on the work of the Education and Research Committee, we are continuing to review some accreditation applications. This process has not been as straightforward as we had thought. I previously published information that we had decided that we couldn't endorse particular products that might enhance sales for an individual company. We hope at our next meeting to explore this further and reach more definite conclusions.

2007 saw the Introduction to Paediatrics course run again in Belfast. The feedback for this was helpful and minor changes will be made the next time it runs. We hope that it will run later this year as several of you have been emailing me about this.

Jeanne Hartley and I have been developing an Advanced Orthopaedic Practitioner 2 day course. This will run in Swindon on 21st and 22nd May, see the advert in the journal. I am pleased to say that our new administrator, Sharon Dyer will be dealing with the bookings for this, the closing date is 20th April, 2008.

A sub group of the committee have been working for some time on a competency framework for paediatric physiotherapists. This work has had a temporary change in emphasis whilst we work on a position statement in response to the Darzi report, giving examples of good practice.

Work is still ongoing to amend the Guidelines for Statementing and this topic will be introduced on the Introduction to Paediatrics 4 day course.

I am well aware of the constraints of funding for attending courses so we aim to keep our costs as low as we can, I hope to meet some of you in May who are able to come to Swindon.

Dawn Pickering

Regional and Affiliated Group Reports

SOUTH WEST

First things first – I would like to introduce myself as the new south west regional representative. I work as a paediatric physiotherapist at Poole Hospital and I am part of both the Child Development Centre and also the schools team. I moved there from North Hampshire Hospital in June last year – after commuting 125 miles a day from Bournemouth to Basingstoke, for 2 ½ years. Both me and my car had seen more than enough of the M3!! Plus my breakdown membership was becoming expensive!!

Secondly – and more importantly, I would like to say a big thank you on behalf of the SW committee to Lynda New who is standing down as our chair person. I think everyone would agree she has done a fantastic job (both for the APCP as a whole and also in providing everyone with cakes and buns at our regional meetings!).

We would also like to welcome back Sue Close from maternity leave, who will be taking over as our regional chair person.

Let's see then: plans for this year. In October we will be holding our regional AGM at Salisbury hospital (following the success of last year). Dates to be confirmed. We are also looking over all of the brainstorming ideas we received from therapists who attended last years AGM, with regards to possible courses to run. Many thanks to you all for your suggestions.

I wish everyone a Happy Easter, and I look forward to meeting you over the coming year.

CHARLOTTE KARMY

SCOTLAND

As I sit here writing this report there are severe weather warnings whizzing around forecasting gales, snow and blizzards... the joys of being in the North of Scotland! Let's hope it makes for good skiing conditions.

It has all been rather quiet up here since I last wrote. Our main focus has been collating ideas for study days and the organisation and planning of our next event. We have been very lucky to get Sue Mailard from Great Ormond Street Hospital to speak on Hypermobility Syndrome and Pain Management, so it should prove to be a very informative day. The venue will be at the Adelphi Centre in Glasgow on

Friday 14th March 2008 – please see the flyer and application in the Journal. Places are limited, so book early if you can! We are also hoping to have an area for poster presentations, so if anyone has a presentation that they would like to display – please get in touch.

If any members have moved house, changed their telephone number or contact details, please could you inform the membership secretary to enable records to be kept up to date and ensure that everyone is kept informed re what is happening in the region? Thank you!

If members would like to receive information by email as opposed to snail mail, this would greatly reduce postage costs and save a fair few trees into the bargain! Please send me your details to: Julie.Burslem@hpct.scot.nhs.uk

I look forward to seeing some of you at the study day!

JULIE BURSLEM

NORTH EAST

Our first study day this year is now on 23rd April (previously advertised as 16th).

It will be an Introduction to Sensory Integration presented by Lynne Witzmann, a paediatric physio from Barnsley. The course is being held at Pontefract General Infirmary and will also include the AGM. Places are limited to 30 so please book early. Further information and an application form can be found on iCSP under the events section.

Our next event will be to host the National Conference in Leeds. Please mark the 14th and 15th November in your diary. Full details will appear in the next journal.

Our thanks go to Mary Harrison and Teleri Robinson who have joined the committee to give us the benefit of their expertise from organising previous conferences.

HEATHER ANGILLEY

LONDON

Hi everyone. As I write this I am listening to the builder pulling the ceiling down in my son's bedroom – following a water leak. It sounds pretty dramatic and I may have to go and check it's just the ceiling! My son is a 'cling on' with a temperature of 39, who is not impressed by the fact I am trying to ignore his moans and groans in order to type this and that I won't watch Dr Who with him for the 4th time today. However you may be more impressed with my Dr Who knowledge than by my APCP report.

Regional and Affiliated Group Reports

Something very exciting for us is that Vathana Sackett has stepped up as London Committee's new Chairperson. Vathana has been on Committee for a couple of years and is currently a clinical specialist at University College Hospital. We'd like to thank her in advance for taking up this position.

The APCP web site has a new look and we have been asked to put together a London page, which will include a profile of current Committee members. We have discussed other information that should be available on our page and would like your comments as to what you want to see there. Please write to or email Christina Rafter raftec@gosh.nhs.uk with your suggestions.

The evening lecture programme will hopefully be finalised for the coming months. We are very keen to access some of the excellent research projects being done by you all! We have approached a few people we know, who have recently completed projects, to come and be part of an evening where maybe 3 or 4 speakers will share their findings. We hope that the format will be similar to presenting a short paper at conference i.e. short and snappy with time for discussion. We really feel there are many people, perhaps not brave enough to put themselves forward for a conference, who may be happy to present to a small audience and share ideas. If you know of anyone in this situation who may need some encouragement please suggest they get in touch. We are happy to help with presentations.

A date for your diaries – our AGM will be held on 24th September. The accompanying lecture is yet to be confirmed but we will let you know as soon as possible.

APCP have been working really hard on your behalf to keep paediatrics on the agenda at the CSP and to represent your views nationally with other health and government groups. Don't forget to encourage people to join APCP, your support really makes a difference, and keep looking out for our events during the year.

Well the Odds are about to destroy the planet so I must go. Perhaps that's them in my son's bedroom!

STEPHANIE CAWKER

TRENT

SUZANNE LAWRENCE

WEST MIDLANDS

We are planning to hold another forum this October, following on from the very successful standing frame forum last year. The next forum will be on "therapeutic walking", we will be sending out more information in the next few months.

The group are planning to write up a piece on the standing frame forum, to be included in the APCP journal so please look out for this.

Further ideas on topics for future forums can be emailed to me on, helen.bayliss2@nhs.net.

HELEN BAYLISS

SOUTH EAST

LUCY ERASMUS

EAST ANGLIA

We held the regional AGM in November '07 with the BEAM and the Fizzy programme study day which was well attended by physios and occupational therapists. This year we will aim to have the regional AGM before November to fit in with the national AGM.

We are hoping to have a study day in June '08. The speaker is yet to be confirmed. Fliers will be sent to all members and the advert will be published in Frontline and the APCP journal.

The East Anglia committee has continued to meet on a regular basis however we are struggling to appoint a chair or regional representative. So if you are interested please get in touch. The committee would like to thank June Fisher who will be retiring from the East Anglia committee. June has served her term as a committee member and as the treasurer in 2007. We would like to thank June for all her ideas, hard work and enthusiasm. Our best wishes to June.

PRIYA JACKSON

WALES

NORTH WEST

The North West committee continues to meet four times a year and is in the process of arranging this year's study day and AGM for October, with another course planned for the summer. The cycling course 'On Yer Bike' held last year received very positive feedback from course participants and is awaiting accreditation from APCP. A study day on Neuromuscular Disease and NIV/ventilation was also well received. Unfortunately there was very poor attendance at the AGM/study day in

Regional and Affiliated Group Reports

September but we hope to see many more of you attending this year.

Elaine Lloyd has completed her term as northwest rep and the committee would like to thank her for her work over the past four years. New committee members are always welcome and we would encourage you to join as it is very good for your KSF/CPD and a great way to become involved in APCP and the work they do on behalf of paediatric physiotherapists. The next meeting will be in April.

A reminder to members, videos can be loaned from the multi-media library. If you have any suggestions for DVDs/videos that could be added to the collection we would like to hear from you. Also applications for bursaries towards study/course fees are welcomed.

As a committee we will continue to work on your behalf and are always interested in hearing from you.

SIOBHAN GOLDSTRAW

NORTHERN IRELAND

It has been a busy and exciting time for NI APCP, we have recently formed a conference organising committee to get the ball rolling for hosting the event in Nov '09. Plans are ongoing and we welcome input and suggestions from all our members.

The regional AGM for Northern Ireland APCP was held in Antrim area hospital on 15th Oct '07 at 7pm. This was in conjunction with an interesting and informative evening talk by the Cedar Foundation on Transition services. Despite this central location, widespread publicity in Northern Ireland's physio depts (and wine and cheese!!!) we had a very disappointing turn out.

On 12th May 2008 Tabib Dabir from the genetics department, BCH will be giving a talk. Venue, time and content to be confirmed.

NI APCP committee continues to work on behalf of its membership, we encourage your input and ideas and would really appreciate an increase in the support of arranged events.

JENNY SINCLAIR

SPECIAL CARE INTEREST GROUP

The CCG held a study day on 20th July in Newcastle which was well received by all who attended. Thanks to Michelle Mooney for organising and overseeing the day. During the study day the AGM

was held. Dave Morgan gave the Chairperson's report acknowledging the achievements of the group since agreeing its constitution last year in Sheffield. He also outlined future aims of the CCG; this incorporated encouraging the membership to take active roles in some of the collaborative work planned. Such work included the broncho-alveolar lavage / mucolytic standards and Acute NIV data collection. Discussions were had regarding the issue of extending the membership to include all aspects of paediatric respiratory care. A vote of the members present established a consensus that this should be more broadly considered by the membership. Michelle Mooney agreed to contact Laura Wiggins to discuss the matter further. Sarah Hines officially stepped down as Treasurer and Mel Lindley was voted in. The accounts were presented by Mel Lindley showing a Balance of £2842.68 at year end 2006 and current balance of £2669.25. A summary of the membership was also given.

The CCG were looking forward to their study day which was to be a satellite day alongside APCP conference and had arranged what the committee felt to be an interesting programme with a wide range of topics and speakers, all of a very high standard. The CCG committee were disappointed to hear that the numbers were low and the subsequent decision to cancel. All speakers expressed that they would be happy to speak again if the day was to be repeated in the future.

Attention is now turned to developing the collaborative work around mucolytics and a plan has been drawn up to work towards a health technology assessment around this topic.

MEL LINDLEY

NEUROMUSCULAR SPECIAL INTEREST GROUP

1. Education

The Scottish branch of the neuromuscular SIG ran a course on respiratory management in neuromuscular disorders in November 2007. The course was well attended and fully subscribed. A profit in the region of £700 was raised and this money will help to support future courses run by the respiratory group. Our thanks go to Anne Keddie, Pierette Melville and Lesley Wotherspoon for their help and support which was essential for the success of the course.

2. Committee

Jennie Sheehan, Committee member has had to stand down due to ever-increasing work commitments and we would like to thank her for her input over the past three years. Marina Di

Regional and Affiliated Group Reports

Marco, Chairperson, will be stepping down in May 08. An invitation to all members of the group has been issued to step into a committee position but to date no one has come forward. This will seriously impact on the future of the group as Elaine Scott, Secretary will also be stepping down at the end of the year. The AGM is scheduled for May 2008 and the future of the group will be discussed at this meeting.

3. Evidence Notes

Elaine Scott is heading up the work in this field which continues to progress. Due to re-organisation within the CSP, Ralph Hammond is no longer our contact however Elaine remains in contact with Dr. Pandyan at Keele University.

4. AGM

Once again, MDC are kindly supporting the Neuromuscular SIG in the running of the May 2008 course and AGM. This one-day course will focus on spinal management and orthotics as well as an update on the North Star Project from Elaine Scott and SMARtNET Project from Anna Mayhew. For further information on this course, please contact Elaine Scott (E_Scott@btopenworld.com).

5. November 2008 Annual Conference

The Neuromuscular SIG have been asked to host the parallel session at this years conference in Leeds. The keynote speaker will be Dr. Imelda de Groot, a well known speaker in the field of QoL. Our thanks to Lindsey Pallant who is working hard on behalf of the Neuromuscular SIG to liaise with the APCP National Committee to ensure smooth running of the conference.

MARINA DI MARCO

PPIMS

CAROL MCKAY

THE 35th APCP CONFERENCE 2008

Venue : The Village Hotel, Leeds

Dates : 14th and 15th November

Host : NE Region of APCP

Many of you are experiencing difficulty getting study leave and financial help for courses. This year's conference is themed to help you link parts of the course to your KSF. It is hoped that this will enable you attend at least part of the proceedings.

The venue is conveniently located on the Leeds ring road and close to both the airport and the city centre. The A1, M1 and M62 motorways are also easily accessible.

The Conference will be held over two days rather than spread over three days to reduce the cost to the delegates. We have tried to address any difficulties that may arise from this change.

The themes that will be addressed at the conference are :

- Neurodevelopment
- Orthopaedics
- Neuromuscular- the NM special interest group will be running a parallel day on the 15th

Full details will be available in the June journal and on iCSP with a link to the NEW APCP website when it is launched.

APCP CONFERENCE 2008

CALL FOR ABSTRACTS

The Education and Research committee would like to invite abstracts for this year's conference. Please submit an abstract of no more than 300 words with your name and contact details on a word document by 1st July 2008 to <mailto:pickeringdm@cf.ac.uk>. The topic should be related to the broad spectrum of paediatric physiotherapy, it could be an audit, research, treatment approach, or report of a novel initiative.

APPLICATION FORM FOR A.P.C.P. PUBLICATIONS

February 2008

2007.

Information to guide good practice for Physiotherapists

Working with Children member £7.00
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Paediatric Outcome Measurement £20.00

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2002.

Paediatric Physiotherapy Guidance for Good Practice £5.00

Obstetric Brachial Plexus Palsy

A guide to physiotherapy management £10.00

Hip Dislocation in Children with Cerebral Palsy

A guide to physiotherapy management £7.50

Evidence Based Practice

- Management of Obstetric Brachial Plexus Palsy(out of print)
- Hip Subluxation & Dislocation in Children with Cerebral Palsy £3.00

Paediatric Manual Handling

– Guidance for Paediatric Physiotherapists £10.00

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– Lessons from Purdon Martin by Dr J Foley £5.00

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Book Review

Physiotherapy for Children

Teresa Pountney,

Butterworth Heinemann, Elsevier 2007

ISBN-13: 978-0-750-68886-4

The authors state that this book is aimed at physiotherapists who are new to paediatric physiotherapy. For me, this is a book that any paediatric physiotherapist regardless of their grade or experience should have on their bookshelf.

It is a great clinical manual and comprehensive reference guide on paediatric physiotherapy. The book is split into several sections which follow a logical manner. It has pertinent chapters including delivering paediatric physiotherapy, ethical issues and justification for intervention, in the form of clinical outcomes. There are several clinical parts covering all core aspects of paediatrics. These include:

- Cardio-respiratory
- Musculoskeletal
- Neurology
- Oncology and palliative care
- Child and adolescent mental health


The chapters are written by expert clinicians in their speciality, based on evidence and combine both theory and practice. The chapters are set out clearly and in an easy to read style. There is an abundance of pictures and diagrams that clearly illustrate and support the text.

This book is a great companion for any physiotherapist working with children in an acute or community setting. A great addition to any departmental library.

Jemma Mears

Birmingham Children's Hospital

Are you a member of Paediatric Network?



Find out what your
peers are thinking...

iCSP Paediatric Network

The paediatric network continues to be one of the largest and most active on iCSP. Thank you to all who contributed throughout 2007 and we look forward to many interesting and stimulating submissions in the coming year.

We are able to submit some of the material, which is relevant, to other CIOG networks so that the items receive a wider audience. This also raises the profile of APCP.

There are some APCP members who are not yet registered with the paediatric network. If this is you, now is the time to act. You are missing out on some great debates and events. You can log onto the website and select "change your networks" located under "manage your

account" from the menu on the left side of the screen. You can then add the paediatric network to your list.

You can also access the APCP website via iCSP or directly using www.apcp.org.uk

This site has a public and member only section. The site is currently being updated and is shortly to be re-launched with added features such as the ability to renew membership on-line and book courses and Conference.

Why not make both of these websites a "favourite" on your tool bar, then they are just a "click" away!

Happy surfing!

The Moderator Team

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connecting the profession

Have you registered?

MEMBERSHIP APPLICATION/RENEWAL

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NB. Any member who has arranged to pay by Direct Debit and then duplicates their subscription with a cheque will be refunded on request. They will, however, incur a £3.00 penalty to cover Administrative costs.

- 1) Ordinary Membership is open to annually subscribing members of the Chartered Society of Physiotherapy.
- 2) Associate Membership is open to professional people with an interest in Paediatrics, subject to the approval of the National Committee.
- 3) Associate Membership is also open to Physiotherapy Students at half the total annual subscription. Students are not eligible to pay by Direct Debit.
- 4) **Annual subscription is £40.00**, and runs from 1st January to 31st December.
- 5) Retired Members are only required to pay half the total annual subscriptions.

All cheques should be made payable to APCP

I wish to *apply for/renew my membership of the Association of Paediatric Chartered Physiotherapists.

*Delete which is not applicable. PLEASE USE CAPITALS ON THIS FORM.

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Why not study PAEDIATRIC PHYSIOTHERAPY at Queen Margaret University, Edinburgh in 2008/09.

This very successful 30 credit Masters module is run by Queen Margaret University in association with the Association of Paediatric Chartered Physiotherapists and takes a thematic approach to paediatric physiotherapy.

The module is studied on a part-time route with six blocks of study. Three of the study blocks are intensive periods of study requiring attendance at QMU (15-19 September 2008; 12-16 January 2009 and 4-8 May 2009). These blocks are facilitated by specialist Paediatric physiotherapists and consist of specialist lectures, tutorials and group sessions. The remaining 3 study blocks are directed independent study, supported through webCT.

Content

This module requires the student to critically appraise issues relevant to clinical effectiveness in specific areas of paediatrics. The module provides students with the opportunity to develop their ability to evaluate current clinical practice through focusing on relevant topics in selected areas of paediatrics (e.g. ethical issues, psychosocial issues; clinical assessment and treatment approaches)

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ASSESSMENT: The module is assessed by a critical literature review and a research ethics proposal

PRE-REQUISITES

Students must hold membership of a recognised professional body (CSP or COT), an honours degree or an ordinary degree or diploma plus appropriate work experience.

Further details of the Paediatric Physiotherapy module can be obtained from:

Jane Hislop (Module co-ordinator)
mailto:jhislop@qmu.ac.uk
☎ 0131 474 0000

Further details of the MSc Physiotherapy programme can be obtained from:

Gillian Baer (Programme Leader)
mailto:gbaer@qmu.ac.uk
☎ 0131 474 0000



APCP Study Day

Friday 14th March

Adelphi Centre Glasgow
www.adelphicentre.org

HYPERMOBILITY SYNDROME IN CHILDREN

By
Sue Maillard
Great Ormond Street Hospital

Registration
9.00am – 9.45am

Close
3.30pm

Lunch Included

Application Form For APCP Study Day

Friday March 14th

Name

Address

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Post Code..... Tel No

Place of Employment

APCP Membership Number

Course Fee	APCP Member	£ 35
	Non-Member	£ 50

Closing Date 22nd Feb 2008

**Completed application form to include cheque payable to APCP
and a stamped self address enveloped to:**

**Mrs Gillian Ferguson
316 Wedderlea Drive
Glasgow G52 2SD**

gferguson2@nhs.net



Association of Paediatric Chartered Physiotherapists

Advanced Paediatric Orthopaedic Physiotherapy Course

21st, 22nd May 2008

Cost: £175, including lunch

At Touchbase Swindon

Facilitated by
Jeanne Hartley and Dawn Pickering

By the end of the 2 days delegates will have explored options to develop their clinical reasoning, including the use of reflective practice in enhancing their learning.

**Applications to: Sharon Dyer, APCP, c/o electrodoc Solutions,
PO Box 52666, London N7 6YW
email: electrodoc@btinternet.com**

Closing date 15th April 2008

Association of Paediatric Chartered Physiotherapists
Application Form for Advanced Paediatric Orthopaedic Course

Touchbase Meetings, Swindon (West),

Lydiard Fields, Great Western Way, Swindon, SN5 8UY
(<http://www.letstouchbase.co.uk>)

21st & 22nd May 2008.

Name of Delegate

Address

.....

Tel: Mobile

E-mail

Is your Employer funding this course? yes [] no []
(please attach PO)

Name of Employer

Address

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Tel:

Type of work (e.g. age of children, conditions, settings)

Special Dietary requirements for lunch

**Please make your cheques payable APCP for £175 & return with your
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2007 Information to guide good practice for Physiotherapists Working with Children

What does the guidance cover?

- the importance of child focused planning
- how to keep children safe
- how to ensure that children and young people make choices
- how to develop services in line with Government guidance
- the importance of location and partnership working
- the role of physiotherapy in improving quality and life chances for children.

This document is available in
a format for people with
vision impairment.

The Association of Paediatric
Chartered Physiotherapists



All babies, children and young people deserve the best possible care, to help them achieve their optimum potential, and address their health needs, safety and development.

Physiotherapists who work with children must have an understanding of:

- child development
- childhood diseases and conditions that may impact on development and well being
- the impact that having a disabled child or a child who is sick has on family life
- processes to address child protection
- health and social care policy in the development of children's services.

Physiotherapists who work with children must engage in:

- continuing professional development to develop their skills and practice
- multi-professional and child focused planning
- therapeutic interventions that enable and optimise development and well being
- supporting children and young people to make choices.

The CSP has launched, in conjunction with the Association of Paediatric Chartered Physiotherapists (APCP), a document to:

- help physiotherapy staff working with children to consider and provide the best service to address individual and family needs
- help commissioners understand the value of physiotherapy in the wellbeing of children
- raise awareness of the breadth and specialisms within paediatric physiotherapy practice, the value of physiotherapy in service delivery and locations where physiotherapy is provided
- provide easy access to contact details for a wide variety of services and activities that may be helpful for children and young people, and including sport and leisure facilities available for those living with a disability
- support knowledge and awareness of the relevant government policies affecting services for children and how key changes in children's services impact on delivery
- describe the regulation and responsibilities of physiotherapists and the competences required to work with children.

2007 Information to guide good practice
for Physiotherapists Working with Children

Writing for the APCP Journal

The aim of the APCP Journal is a forum to disseminate original research, facilitate continuing education for paediatric physiotherapists and provide an opportunity to debate all controversial issues.

Most articles should be no longer than 3,000 words excluding references and abstract. The types of article identified to achieve these aims include:

Peer reviewed articles

Papers submitted under this section are all reviewed blind.

• *Research Report*

A report which permits examination of the method, argument and analysis of research using any method or design (quantitative, qualitative, single case study or single case design etc).

• *Scholarly paper*

A paper sharing ideas and experience or reviews in a specific area of practice

• *Audit Report*

A report which contains examination of the method, results, analysis, conclusions and service developments of audit relating to children and physiotherapy, using any method or design.

• *Review Paper*

A critical appraisal of primary source material on a specific topic related to children.

• *Treatment Report/Case Studies*

A report of the treatment of a child or series of children which provides a base line description of established treatments, or a new insight into the techniques or treatment of children with a specific problem.

Case reports should be no longer than 2,000 words.

• *Technical Evaluation*

A description of a mechanical or technical device used in assessment, treatment, management or education to include specifications and summary evaluation.

• *Service Development Report*

A report of changes in service delivery aimed at improving quality.

Other types of Editorial Material

• *Abstracts of Theses and Dissertations*

Abstracts from research projects, including those from undergraduate or higher degrees, audits or presentations. They should be up to 300 words and where possible the conventional format: introduction, purpose, method, results, discussion, conclusion.

• *Letters and replies to APCP*

These can be about any issue pertinent to paediatric physiotherapy or APCP. They may relate to material published in the previous issue(s) of the APCP journal. Copies of replies to editor.

• *Book reviews – up to 500 words*

Preparation of Editorial Material

Copy should be produced in Microsoft Word. Wherever possible diagrams and tables should be produced in electronic form, e.g. Excel, and the software used clearly identified.

The first page should give:

- The title of the article
- The names of the author(s)
- A complete name and address for correspondence
- Up to three relevant professional and academic qualifications for all authors and their current positions
- Any source of funds supporting the work
- The title, date and location of the conference if the paper is an adaptation of a presentation.

All Peer-reviewed Articles

The title page should give:

- The title of the paper
- Up to five key words.

- A structured summary of no more than 300 words explaining the purpose and summarising the key points and conclusions. For research reports this should be under the headings of:
- Background and Purpose
- Methods
- Results of Findings
- Conclusion

Copy should be:

- typed or printed
- double spaced
- on one-sided A4 paper with at least a 1" margin all round
- Consecutively numbered
- include the name, qualifications, current position, and contact address of the author(s).

The text should be well organised and written in simple and correct English under appropriate headings. The positions of tables and figures should be indicated.

References

References should be in the Harvard style:

In *text*, cite only the author(s) surname(s) followed by the date of publication, eg (Robinson, 1994) or Robinson (1994). Use a, b, etc, to indicate more than one publication by the same author(s) in the same year (eg 1992a, b). For three or more authors of a cited paper, name the first followed by et al, eg (Smith et al, 1990).

In the reference list, include articles in journals and books alphabetically by author.

For citations from journals, give the names and initials of all authors (year of publication), title of the article, full name of the journal, volume number, issue number and first and last page numbers, eg **Brown, A, Green, B and Gold, C (2001)**. 'The value of exercise', *Physiotherapy*, **87**, 1, 77-79.

Referring to books, give the names and initials of all authors/editors (year of publication), title, publisher, place of publication, and the chapter number or the page number of the citation or both, eg **Gardner, M (2001)**. *The Annotated Alice*, Penguin Books, Harmondsworth, Chap 10, page 210.

Tables

Give them an appropriate title and number them consecutively as they are referred to in the text. Use only horizontal lines. Explain all abbreviations in a footnote. Place tables on a separate sheet after the references.

Figures and photographic images

Number them consecutively as they are referred to in the text and place on separate sheets after the tables. List all captions (legends) on a separate sheet.

Permissions and Ethical Certification

Protection of subjects: Written permission from children, parents or guardians to publish photographs of recognisable individuals must be enclosed with the material, or obscure facial features. For reports of research involving people written confirmation of informed consent is required.

Any paper based on a study of children, families or staff, submitted to the APCP journal, must have received ethical approval and state by which REC committee. If for any reason your study is exempt, you must make a statement with the covering letter explaining why it is not applicable.

The use of names for children is encouraged in case studies for clarity and humanity, but they should not be their real names.

Submission of Articles

A disk or CD Rom and 2 hard copies of each article should be sent with a covering letter from the principal author stating the type of article being submitted.

THE APCP RESEARCH GROUP REGISTER

If you would like to be a member of the APCP research group, please fill in the form below and return it to **Jeanne Hartley, Research Officer, 36 Cascade Ave., Muswell Hill, London N10 3PU**. This information will be used to inform you of research study days and help us to learn more about our members' research interests.

Name

Contact
Address

Post Code

Tel. No.

Fax No.

E-Mail:

What are your research interests?

Are you undertaking any type of research project large or small? **YES/NO**

If yes please give a brief summary . . .

Would you be happy for other physiotherapists with similar research interests to be put in touch with you? **YES/NO**

Thank you for completing this form.

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